

CERTIFICATE OF DEATH

Reg. Dist. No. 245

8572

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 6 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescing Home, Hyattsville, Md.				e. STREET ADDRESS 3515 University Land,			
3. NAME OF DECEASED (Type or print) First Maude Middle Agnes Last Anderson				4. DATE OF DEATH Month August Day 13, Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Jan. 1879	
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Daniels				14. MOTHER'S MAIDEN NAME Clara Ricar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Claude Anderson, Husband Same as no. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Chronic glomerulo-nephritis with uremia. DUE TO (b) Generalized arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 2 wks. 20 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 56, to August 19 56, that I last saw the deceased alive on August 13, 19 56, and that death occurred at 7: P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. 4713 Berwyn Rd. College Park, Md. PHYSICIAN'S NAME (Type) Wolcott L. Etienne, M.D. 4713 Berwyn Road Collage Park, Maryland 8/14/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 August 56		22c. NAME OF CEMETERY OR CREMATORY St. John's Church Cemetery Beltsville Pr. Geo., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE Aug. 17 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPT OF HEALTH-BALTIMORE 10

RECEIVED

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8583

CERTIFICATE OF DEATH

08550

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Daisy Blue</u>				4. DATE OF DEATH <u>Aug. 17, 1956</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 30, 1891</u>	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>SEVERN MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HIRAM GAITHER</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE BYRD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>MRS DORIS SPALDING, LAUREL, MD</u>			
17. INFORMANT <u>MRS DORIS SPALDING, LAUREL, MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Embolus</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypernephroma Right Kidney</u> DUE TO (c) <u>3 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE (Cardio Vascular) Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 9, 1956</u> to <u>Aug 17, 1956</u> that I last saw the deceased alive on <u>Aug 16, 1956</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comenau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 E. RYAN ST</u> DATE SIGNED <u>8/17/56</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMENAU</u>				<u>MT Rainier Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Muirkirk, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hensaldory Laurel Md</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 22 1956</u> 24b. REGISTRAR'S SIGNATURE <u>A. H. Hensaldory</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CITY OF BIRTH

COUNTRY OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CITY OF DEATH

COUNTRY OF DEATH

DATE OF DEATH

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COUNTRY OF DEATH

BUREAU V. S.

AUG 22 1956

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6901 Allentown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harlan Middle Edward Last Bowman		4. DATE OF DEATH Month August Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1908
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel N. Bowman		14. MOTHER'S MAIDEN NAME Cora L. Shepherd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Mary Bowman, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) 420.1 DUE TO (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition BURIAL		22b. DATE THEREOF 8-6-1956	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24. REG'D BY REGISTRAR August 2, 1956	
ADDRESS 517-11th St SE		24b. REGISTRAR'S SIGNATURE A. W. Hedrick	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1956 7 5.15

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8573

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 3 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paint Branch Rest Home		d. STREET ADDRESS 4316 Hartwick Road	
3. NAME OF DECEASED (Type or print) Annie First Ireland Middle Boyle Last		4. DATE OF DEATH Aug Month 14 Day 1956 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Sept, 1868
9. AGE (in years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Kent Boyle		14. MOTHER'S MAIDEN NAME Elizabeth Veitch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fletcher P. Veitch Jr.		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PAGETS DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 53 , to August , 19 56 , that I last saw the deceased alive on Aug 2 , 19 56 , and that death occurred at 5:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau		ADDRESS (Street, city or town, state) 3503 Pennys	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		DATE SIGNED 8/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Casch's Sons Hyattsville, Maryland		24a. REC'D BY REGISTRAR Aug 17 1956 Mrs. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

247

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7219 Central av.</u>				d. STREET ADDRESS <u>7219 Central ave</u>			
3. NAME OF DECEASED (Type or print) <u>BERNARD FRANCIS BRADY</u>				4. DATE OF DEATH <u>August 17, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 7, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BINK. BRADY</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN HAVEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Oscar W. Brady</u> Address <u>Londover, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial heart disease with chronic congestive failure</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 5, 1951</u> , to <u>Aug 17, 1956</u> , that I last saw the deceased alive on <u>Aug 16, 1956</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Ernest E. Cornelsen</u> M.D. <u>4400 Bowyer Pl. SE</u>				<u>8/17/56</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST E. CORNELSEN</u>				<u>Washington 19, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-20-1956</u>		<u>Addison Chapel</u>		<u>Seat Pleasant, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAY 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08554

8534

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundelle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linnet</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>402 Main St</u>		d. STREET ADDRESS <u>Brink Bridge Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Michael David Bright</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Jack Bright</u>		14. MOTHER'S MAIDEN NAME <u>Betty Marie Souder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father & Mother (above)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Enteritis, Acute</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 19</u> , 19 <u>56</u> , to <u>Aug 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>56</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McConey</u> M.D.		ADDRESS (Street, city or town, state) <u>402 Main St</u> DATE SIGNED <u>8/20/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert S. McConey, M. D.</u>		<u>Laurel, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Scaggsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Delbert Davidson, Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 23 - 56</u>	
ADDRESS <u>Laurel, Md</u>		24b. REGISTRAR'S SIGNATURE <u>M. Brashers</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>89. SIGNATURE OF DECEASED [Faint text]</p>		<p>90. SIGNATURE OF DECEASED [Faint text]</p>	
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<p>99. SIGNATURE OF DECEASED [Faint text]</p>		<p>100. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

AUG 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08555

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 3 Mo. 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		36	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 6202 Brooks Road, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle BENJAMIN Last BROWN, Sr.				4. DATE OF DEATH Month August Day 28th, Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9th, 1882		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Louisanna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Benjamin Brown				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lota Belle Brown, 7628 Greeley Road, Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) Fractured Right Shoulder							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and fractured right shoulder					
20c. TIME OF INJURY Month, Day, Year Hour XXX 5/5/56 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Capitol Hgts. Pr. Geo. Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31/1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. S.E. Wash. D.C.				24a. REC'D BY REGISTRAR AUG 31 1956 DATE			
				24b. REGISTRAR'S SIGNATURE James Scurry			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BATH HOUSE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		1956		HOME	
RESIDENT OF		CITY		COUNTY		STATE		MARRIED		OCCUPATION	
JAMES H. HARRIS		BALTIMORE		BALTIMORE		MD		MARRIED		LABORER	
CAUSE OF DEATH		MANNER OF DEATH		EDUCATION		RELIGION		SCHOOLING		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		HIGH SCHOOL		METHODIST		12		NONE	
SIGNATURE OF EXAMINER		DATE		SIGNATURE OF NEXT OF KIN		DATE		SIGNATURE OF WITNESS		DATE	
JAMES H. HARRIS		1956		JAMES H. HARRIS		1956		JAMES H. HARRIS		1956	

RECEIVED
AUG 31 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8586 CERTIFICATE OF DEATH

Reg. Dist. No.

08556
231

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. Hosp		d. STREET ADDRESS Agasco	
3. NAME OF DECEASED (Type or print) First Leo Middle Brown Last Brown		4. DATE OF DEATH Month Aug. Day 19 Year 1956	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-56
9. AGE (In years lost birthday) yrs. 26		10. IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo Brown		14. MOTHER'S MAIDEN NAME Virginia Douglas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Leo Brown		Address Aquasco, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Purulent Meningitis (H. Influe) 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/14, 1956 , to 8/19, 1956 , that I last saw the deceased alive on 8/19, 1956 , and that death occurred at 1:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. H. Bergemann		ADDRESS (Street, city or town, state) 2724 7th St Hyattsville	
PHYSICIAN'S NAME (Type) T. H. Bergemann		DATE SIGNED 2724 7th St Hyattsville	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-56	
22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Aquasco, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold Funeral Home		ADDRESS 2724 7th St Hyattsville	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

2023237XV5

AUG 28 1956

CERTIFICATE OF DEATH

Form 10-1

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 20 1956</i>		5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. MANNER OF DEATH <i>Natural</i>		8. PLACE OF BIRTH <i>Baltimore, Md.</i>		9. DATE OF BIRTH <i>Aug 25 1911</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF DECEASED <i>Yes</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
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91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. 5

AUG 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08558
8574
CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 4 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4019 Kennedy ST				d. STREET ADDRESS 2151 Florida Ave. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Frederick Button				4. DATE OF DEATH Month August Day 19 Year 1956			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 6, 1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTERIOR DECORATOR		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) New York Mills N.Y.	
13. FATHER'S NAME Frederick Button				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Beatha Onmsby				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Margorie Korkisch 4019 Kennedy ST			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 142.1 CARCINOMATOSIS DUE TO (b) CARCINOMA OF PAROTID GLAND Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 28, 1956, to Aug 19, 1956, that I last saw the deceased alive on Aug 9, 1956, and that death occurred at 53 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Omeau				ADDRESS (Street, city or town, state) 3503 Kennedy ST			
PHYSICIAN'S NAME (Type) NORMAN DONAT OMEAU				DATE SIGNED 8/19/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 8-19-56		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) WASH. DC				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Adams				ADDRESS 4728 Wisconsin Ave NW		24a. REC'D BY REGISTRAR DATE Aug 19, 1956	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe				Defect			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
				</																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 2 FilmG201 8-20-56 et
CERTIFICATE OF DEATH

8587

08559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR. Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR. Geo.</u> 16X-2			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 23			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACORDA Rest Home</u>				d. STREET ADDRESS <u>5504 Parkland Court</u>			
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First <u>W.</u> Middle <u>CARRICK</u> Last				4. DATE OF DEATH <u>AUG 10</u> 19 <u>56</u> Month <u>Aug</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 9. 1876</u> 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>80</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT <u>Mr. Richard Langan</u> 6819 Geo. Palmer Hwy			
16. SOCIAL SECURITY NO.				14. MOTHER'S NAME <u>Unknown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) <u>54R3</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MO 2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>TUMOR RT FEMUR WITH PATHOLOGICAL FRACTURE</u> <u>MULTIPLE DECUBITUS ULCERS - CONTRACTURE LEFT ARM</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in Part II or Part I of Form 10-1) <u>FRACTURE (54R3)</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>55</u> to <u>10 AUG</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9 AUG</u> , 19 <u>56</u> , and that death occurred at <u>11:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				ADDRESS (Street, city, town, state) <u>3404 CHEVERLY AVE</u>			
PHYSICIAN'S NAME (Type) <u>CHEVERLY, MD.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 13, 1956</u>		<u>Adrian Chapel</u>		<u>Seaside Pleasant Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. William Lee's Sons Co</u> ADDRESS <u>3001 N. 1st St.</u>				24a. REC'D BY REGISTRAR <u>16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

MARITAL

CAUSE OF DEATH

22

AUG 10

JOHN P. 1876 80

U.S.A.

Maryland

Housewife
Chloroform

Myself and Japan 1818. Substantially

BUREAU V. 2

AUG 16 1956

RECEIVED

102

of the State Department of Health
Baltimore, Maryland 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18560

8588

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MD b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Prince Georges Gen. Hosp.		d. STREET ADDRESS 4723 - Homer Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hilda Clark		4. DATE OF DEATH Month Day Year Aug. 2 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-25
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H-wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Haynes		14. MOTHER'S MAIDEN NAME Elsie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Clark 4723 Homer Ave Suitland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral haemorrhage 330X DUE TO Ruptured congenital aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 7 to 23 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/18, 1956, to 8/2, 1956, that I last saw the deceased alive on 8/2, 1956, and that death occurred at 2:22 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE John Thomas Lord M.D.		2025 Eye St N.W. Washington, D.C.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-1956	
22c. NAME OF CEMETERY OR CREMATORY Washington Hall		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE	
Mattingly Funeral Home - 131-11 St. S.E., WASH. D.C.		24b. REGISTRAR'S SIGNATURE	
		AUG 3 1956	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1911</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1935</i>	
9. NAME OF SPouse <i>Jane Doe</i>		10. NAME OF CHILDREN <i>John Jr. 1940, Mary 1945</i>		11. NAME OF NEXT OF KIN <i>John Doe</i>		12. ADDRESS OF NEXT OF KIN <i>123 Main St, Baltimore, Md.</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. PLACE OF DEATH <i>Home</i>		15. DATE OF DEATH <i>Aug 3 1956</i>		16. TIME OF DEATH <i>10:30 AM</i>	
17. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>Jane Doe</i>	

BUREAU V. S.

AUG 3 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08561

8539

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28 Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thompson</u> Middle <u>Huff</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Aug. 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter Self</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Joshua Clark</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Huff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give year or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>146 10 7023</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung, Metastasis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>1 year</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>56</u> , to <u>Aug 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 15</u> , 19 <u>56</u> , and that death occurred at <u>12.08 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124-41st Ave, Hyattsville, Md</u> DATE SIGNED <u>8/16/56</u>							
ACTUAL SIGNATURE <u>Gorden W. Kelley</u>				M.D. <u>6124-41st Ave, Hyattsville, Md</u>			
PHYSICIAN'S NAME (Type) <u>Gorden W. Kelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mantua Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mantua New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland</u>		24a. REG'D BY REGISTRAR <u> </u> DATE <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

AUG 20 1956

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES JOHNSON		45		M		W		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
1956		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE	
1911		SOUTH AFRICA		HIGH SCHOOL		FARMER		MARRIED	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF BURIAL		PLACE OF BURIAL		CEREMONY	
1935		JANE JOHNSON		1956		CATHOLIC CHURCH		CATHOLIC	
DATE OF INTERVIEW		NAME OF INTERVIEWER		NAME OF WITNESS		NAME OF MINISTER		NAME OF CLERGY	
1956		J. JOHNSON		J. JOHNSON		J. JOHNSON		J. JOHNSON	

BUREAU V. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8632

CERTIFICATE OF DEATH

08562

Reg. Dist. No.

247

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4819 Silver Hill Road</u>				d. STREET ADDRESS <u>4819 Silver Hill Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Judson</u> Middle <u>Gea</u> Last <u>Creedy</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>20</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9-1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A. Creedy</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Rea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>313-124038</u>		17. INFORMANT <u>Edward A. Creedy</u> Address <u>4819 Silver Hill Road Switland Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>162X</u> DUE TO (b) <u>Myocardial Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Bronchogenic Carcinoma - L.U.L.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>August 20</u> , 1956, that I last saw the deceased alive on <u>August 19</u> , 1956, and that death occurred at <u>4:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney W. Lowry</u>				M.D. <u>7200 MARLBORO PIKE SE 28 DC</u>			
PHYSICIAN'S NAME (Type) <u>S. W. LOWRY M.D.</u>				DISTRICT <u>HEIGHTS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-</u>		22b. DATE THEREOF <u>1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>				ADDRESS <u>131-11488 Washington</u>		24a. REC'D BY REGISTRAR <u>ORR</u> DATE <u>AUG 22 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

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MEDICAL CERTIFICATION

A34

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		AUG 22 1956	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PLACE OF DEATH		MANNER OF DEATH	
HOME		NATURAL	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL DISTRICT	
MD		DC	
DATE OF BIRTH		DATE OF DEATH	
AUG 22 1956		AUG 22 1956	
TIME OF DEATH		PLACE OF DEATH	
10:00 AM		HOME	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL DISTRICT	
MD		DC	

BUREAU V. S.

AUG 22 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08563

CERTIFICATE OF DEATH

8633

Reg. Dist. No. 231

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George's</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>PR. Geo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>	
TOWN <u>Hillside</u>		LENGTH OF STAY (in this place) <u>47 yrs</u>		TOWN <u>Hillside</u>		TOWN <u>Hillside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1106-56th Ave.</u>				STREET ADDRESS (If rural give location) <u>1106-56th Ave. 1</u>			
3. NAME OF DECEASED (Type or Print) <u>Alvine F. CROSSMAN</u>				4. DATE OF DEATH (Month) <u>aug</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 22-1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>EDWARD HALFPAPE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ludwig CROSSMAN</u> <u>1106-56th Ave.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1947</u> , 19 <u>8-6-</u> , to <u>8-6-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-6-</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Reuben E. Stone</u>				ADDRESS (Street, city, town, state) <u>M.D. 3417 Minnesota Ave Washington DC</u>		DATE SIGNED <u>8/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial Aug 9-56</u>		DATE THEREOF <u>Aug 9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		LOCATION (City, town, or county) <u>Seat Pleasant</u> (State) <u>MD</u>	
24. REC'D BY REGISTRAR <u>AUG 8 1956</u>		REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bro.</u>		ADDRESS <u>1661-16th St NW WASH. DC</u>	

CERTIFICATE OF DEATH

1956

Reg. Dist. No.

1. NATURAL DEATHS - FORM OF RECORD

2. SEX Male		3. AGE 45		4. RACE White	
5. OCCUPATION Teacher		6. PLACE OF BIRTH New York		7. DATE OF BIRTH 1911	
8. MARITAL STATUS Married		9. PLACE OF DEATH New York		10. DATE OF DEATH Aug 8, 1956	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. SIGNATURE OF PHYSICIAN J. H. Smith	
14. SIGNATURE OF REGISTRAR J. H. Smith		15. SIGNATURE OF WITNESSES J. H. Smith		16. SIGNATURE OF DEATH CERTIFICATE J. H. Smith	

BUREAU V. S.

AUG 8 1956

RECEIVED

1911
Aug 8, 1956
J. H. Smith
J. H. Smith
J. H. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8590

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08564

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Irvington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith Vistery Dawson		4. DATE OF DEATH August 4, 1956	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1906	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR: Months 83 Days x-3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin G. Clarke		14. MOTHER'S MAIDEN NAME Martha K Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. William C. Christopher	
17. INFORMANT William C. Christopher		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial pressure DUE TO 330x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous subarachnoid hemorrhage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 4, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/56	
22c. NAME OF CEMETERY OR CREMATORY Bulah Cemetery		22d. LOCATION (City, town, or county) (State) Lively Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REG'D BY REGISTRAR AUG 7 1956		24b. REGISTRAR'S SIGNATURE R. W. Schuch	

106 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 12, 13, 14 Film G202 8-31-56 et

8591

CERTIFICATE OF DEATH

Reg. Dist. No. 21

085654

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DuPont Hts. md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges		d. STREET ADDRESS 4416 Campbell DR.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAURA DENT		4. DATE OF DEATH Month Day Year Aug 19 1956	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-72
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pri. Geo. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Galloway		14. MOTHER'S MAIDEN NAME Henrietta Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary Embolism (b) Histio cytic Anemia (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-19, 1956, to 8-19, 1956, that I last saw the deceased alive on 8-19, 1956, and that death occurred at 2:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ronald S. Fleischer M.D.		ADDRESS (Street, city or town, state) 1732 Queen Chapel Rd. DC	
DATE SIGNED 8/20/56			
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug-23, 56	
22c. NAME OF CEMETERY OR CREMATORY WOOD LAWN		22d. LOCATION (City, town, or county) (State) DC	
23. FUNERAL DIRECTOR'S SIGNATURE M.K. Rollins		ADDRESS 4339 Hunt Pl	
24a. REC'D BY REGISTRAR DATE Aug 22 1956		24b. REGISTRAR'S SIGNATURE Corree Campbell	

BUREAU V. S.

1956 2 E.

RECEIVED

8592

CERTIFICATE OF DEATH

Reg. Dist. No.

18566
239

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b 36 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 158 Lafayette Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 158 Lafayette Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry J. Dudley		4. DATE OF DEATH Month Day Year Aug 12, 1956 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1867 9. AGE (In years last birthday) 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Stephen Dudley		14. MOTHER'S MAIDEN NAME Elizabeth A. Holbrooke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. John A. Jones, 158 Lafayette Ave, Laurel, Md.	
17. INFORMANT John A. Jones, 158 Lafayette Ave, Laurel, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema - Hypertension 443x DUE TO Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO arteriosclerosis - myocardial infarction (c) arteriosclerosis - myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2 , 19 56 , to 8-12 , 19 56 , that I last saw the deceased alive on 8-12 , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE N B Steward M.D.		ADDRESS (Street, city or town, state) 314 Comp - in Laurel DATE SIGNED 8/12/56	
PHYSICIAN'S NAME (Type) N B Steward			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1956	
22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Roush ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR Aug 15 - 56 24b. REGISTRAR'S SIGNATURE M. Brashear	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MOBILE, ALABAMA		ATTORNEY		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
APRIL 4 1968		MEMPHIS, TENNESSEE		4:00 PM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE NATIONAL DEATH INDEXING ACT, AND IS A PART OF THE PUBLIC RECORDS OF THE STATE OF ALABAMA.

RECEIVED
BUREAU V. 3
AUG 20 1968

RECEIVED

08567

8593 CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY OR TOWN <u>Laurel</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY <u>83X3</u> CITY OR TOWN <u>Virginia Beach</u> STREET ADDRESS <u>Cavalier Drive Ext.</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY Aurelia Dusch</u>				4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 20-1878</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Henry Amiss</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Elizabeth Roscoe Hathaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or only.) <u>Unknown</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>Frank A. Dusch - son - address above</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260x IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u> at least <u>30yrs.</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>Many years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/20/1935</u> , to <u>Aug 6, 1956</u> , that I last saw the deceased alive on <u>Aug 5, 1956</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Jesse Higgins</u>				M.D. <u>Laurel Maryland</u>		DATE SIGNED <u>8/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried Aug 8, 1956</u>		DATE THEREOF <u>Aug 8, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Marshall Virginia</u>	
24. REC'D BY REGISTRAR <u>Aug 10-56</u>		REGISTRAR'S SIGNATURE <u>M. Beasly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Bonfield</u>		ADDRESS <u>Laurel Md</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 13 1956

RECEIVED

ENCLOSURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08568

8594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Riverdale				c. LENGTH OF STAY IN 1b 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 4306 Tuckerman Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Alexander Last Fearing				4. DATE OF DEATH Month August Day 8 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/59		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Cent.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Fearing				14. MOTHER'S MAIDEN NAME Cordelia Baird			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Malcolm Kerr Same as # 2 Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c) Fractured left femur							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down in his front yard on side walk					
20c. TIME OF INJURY Month, Day, Year Hour 8:00 P.M. 6-12-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) University Park-Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 9th, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 8/9/56		22c. NAME OF CEMETERY OR CREMATORY Robbins Funeral Home		22d. LOCATION (City, town, or county) (State) Williams, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR REG 13 1956	
				24b. REGISTRAR'S SIGNATURE Gasch			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

AUG 13 1956

RECEIVED

8634

CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY <u>PR Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltersville, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 Mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4411 - QUCCA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> 02-10-2	
		d. STREET ADDRESS <u>40 FRANKLIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>MARGARET</u> Middle <u>FELDMAYER</u> Last		4. DATE OF DEATH <u>AUG</u> Month <u>1</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27, 1900</u> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Zealous Yingling</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-24-5884</u> INFORMANT <u>PROPS</u> Address <u>4411 Qucca Beltsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL Myeloma (Metastatic)</u> DUE TO <u>Myeloma - Thoracic Spine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>AUG</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JULY 31</u> , 19 <u>56</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		DATE SIGNED <u>4713 - BERWYN RD</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		<u>COLLEGE PARK, MD</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>—</u>	22b. DATE THEREOF <u>8-3-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) <u>Annapolis MD</u> (State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>8/2/56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

BUREAU V. S.

AUG 3 1956

RECEIVED

CERTIFICATE OF DEATH

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8635

CERTIFICATE OF DEATH

Reg. Dist. No.

085704

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN 1b <u>25 years</u>		d. STREET ADDRESS <u>Route 2, Box 416</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank William Ferrel</u>		4. DATE OF DEATH <u>August 5, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1892</u>
9. AGE (In years, last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bloomsburg, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>P.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lymon Ferrel</u>		14. MOTHER'S MARRIED NAME <u>Eva Loup</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-19-388</u>	
17. INFORMANT <u>Son: Lymon J. Ferrel</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis of coronary artery</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-15-52</u> to <u>8-5-56</u> , that I last saw the deceased alive on <u>7-30-56</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard Gitter</u> M.D.		ADDRESS (Give city or town, state) <u>656 East Cap St., Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD GITTER, M.D.</u>		DATE SIGNED <u>Aug 10 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co., Washington, D.C.</u>		24. REC'D BY REGISTRAR <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

Form with various fields for death certificate, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

Form with fields for date and name. Includes the text "RECEIVED" and "BUREAU V. S.".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8636

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08571

282

<p>1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morning side</p>				<p>c. LENGTH OF STAY IN 1b 5 month</p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not, in hospital, give street address) 6211 Mc Keldin Herne</p>				<p>d. STREET ADDRESS 6211 Mc Keldin Herne</p>			
<p>3. NAME OF DECEASED (Type or print) Catherine Lena Frederick</p>				<p>4. DATE OF DEATH Month Day Year Aug 19 1956</p>			
<p>5. SEX Female</p>		<p>6. COLOR OR RACE Colored</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Jan 30 1882</p>	
<p>9. AGE (In years last birthday) 74 yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>IF UNDER 24 HRS.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY Sun Hall</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		<p>13. FATHER'S NAME Henry Thomas</p>	
<p>14. MOTHER'S MAIDEN NAME Susan Young</p>		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Joseph Frederick, Baltimore, Md.</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19</p>		<p>20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</p>							
<p>ACTUAL SIGNATURE James I. Boyd</p>				<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>EXAMINER'S NAME (Type) James I. Boyd</p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				<p>DATE SIGNED Aug 19, 1956</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>22b. DATE THEREOF 8/22/56</p>		<p>22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY</p>		<p>22d. LOCATION (City, town, or county) (State) BUSHWOOD, Md.</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE B. Robinson</p>				<p>ADDRESS LEONARDTOWN, Md.</p>			
<p>24a. REC'D BY REGISTRAR</p>		<p>24b. REGISTRAR'S SIGNATURE</p>		<p>DATE 8/20/56</p>		<p>24c. REGISTRAR'S SIGNATURE</p>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial/cremation or removal.

AUG 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08573

Reg. Dist. No.

137

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnuder Ferry Road</u>				d. STREET ADDRESS <u>Magnuder Ferry Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Catherine</u> Last <u>Goldsmith</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 12, 1918</u>		9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George J. Short</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Hanlon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Howard L. Goldsmith same as II.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>9140</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>short circuit in vacuum cleaner</u> (c) <u>cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injured in a vacuum cleaner that short circuited</u>					
20c. TIME OF INJURY Month, Day, Year <u>11:00 a.m. 8/18/56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) (County) (State) <u>Westwood P.S. Md</u>							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Aug 18, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Horsehead Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ritchie Brothers Upper Marlboro, Md</u>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>John F. Deneen</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
AUG 23 1956
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1
4
5
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08574

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Prince Georges General Hospital		e. STREET ADDRESS 4310 Baltimore Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Hubert Earl Greene		4. DATE OF DEATH Month Day Year August 29 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1928
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction engineer		10b. KIND OF BUSINESS OR INDUSTRY Road construction	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marcus Greene		14. MOTHER'S MAIDEN NAME Mary Lou Futch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Tessier, 5506 40th Ave, Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Road grading machine went thru guard rail of bridge and overturned in ravine below pinning deceased underneath.	
20c. TIME OF INJURY Month, Day, Year 3.15 p.m. 8-29-56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Lenham, Pr. Geo. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John J. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 30, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transhumation		22b. DATE THEREOF 8/31/56	
22c. NAME OF CEMETERY OR CREMATORY Jacksonville		22d. LOCATION (City, town, or county) (State) Florida	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche son Hyattsville Md		ADDRESS	
24a. REC'D BY REGISTRAR SEP 7 1956		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name (Print)		John T. Lutz	
Sex		Male	
Age		38	
Date of Birth		Jan. 10, 1928	
Place of Birth		Florida	
Occupation		Construction engineer	
Address		1930 Baltimore Avenue	
City		Baltimore	
State		Maryland	
Date of Death		August 22, 1956	
Cause of Death		Coronary arrest	
Manner of Death		Natural	
Signature of Examiner		Charles T. Lutz	
Signature of Physician		Charles T. Lutz	
Signature of Coroner		Charles T. Lutz	

BUREAU V. S.

SEP 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8579

CERTIFICATE OF DEATH

Reg. Dist. No.

08575
245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4511 32nd Ave</u>		d. STREET ADDRESS <u>4511 32nd Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Adele</u> Last <u>GRIFFITH</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Gent</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Griffith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>332X</u>	
17. INFORMANT <u>Kathryn Flanagan</u>		Address <u>4511 32nd Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1951, to <u>Aug 12</u> , 1956, that I last saw the deceased alive on <u>Aug 11</u> , 1956, and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat (unclear)</u>		ADDRESS (Street, city or town, state) <u>3503 Penny St Mt Rainier MD.</u>	
PHYSICIAN'S NAME (Type) <u>Norman Donat (unclear)</u>		DATE SIGNED <u>8/2/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-15-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Lintner + Son</u>		ADDRESS <u>5132 E. Ave Wash DC</u>	
24a. REC'D BY REGISTRAR <u>Aug 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19 CERTIFICATE OF DEATH

BUREAU V. B.

AUG 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08576

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Fletchertown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Webster Hall				4. DATE OF DEATH Month Day Year August 29 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Road Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick W. Hall				14. MOTHER'S MAIDEN NAME Emma Jane Lounde			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-12-9689		17. INFORMANT Address Maria Hall, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension DUE TO cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 29, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/56		22c. NAME OF CEMETERY OR CREMATORY Church of Ascension		22d. LOCATION (City, town, or county) (State) Bowie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR SEP 5 1956	
				24b. REGISTRAR'S SIGNATURE L. H. Schick			

NEW YORK MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		35		White		1956		New York City	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Address		Date of Birth		Date of Death		Time of Death		Time of Death		Time of Death	
123 Main St.		Jan 1, 1921		Jan 1, 1956		10:00 AM		10:00 AM		10:00 AM	
City		State		County		District		Precinct		Block	
New York		New York		New York		New York		New York		New York	
Zip		Social Security		Identification		Identification		Identification		Identification	
10001		123-456789		123-456789		123-456789		123-456789		123-456789	

BUREAU V. S.

SEP 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

185577

Reg. Dist. No.

243

8638

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halls</u> c. LENGTH OF STAY IN 1b <u>Transient</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Central Avenue</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halls Hill</u> d. STREET ADDRESS <u>1901 Culpepper Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Van Meter</u> Last <u>Harriett</u> 4. DATE OF DEATH Month <u>Aug</u> Day <u>4</u> Year <u>1956</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 15, 1933</u> 9. AGE (In years last birthday) <u>22</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Washer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u> 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Van Meter Harriett Sr</u> 14. MOTHER'S MAIDEN NAME <u>Catherine L. Barber</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>1-203-914-1122</u> 17. INFORMANT <u>Joseph V. Harriett</u> Address <u>Washington, DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Crushed skull and abdomen</u> DUE TO (c) <u>Compound comminuted fracture both legs</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Pedestrian struck by an automobile</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <u>3:00 p.m.</u> a.m. <u>8-4</u> 19 <u>56</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Central Avenue</u> 20f. (City or town) <u>Halls</u> (County) <u>D.C.</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 4, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stoodlaw</u>		22d. LOCATION (City, town, or county) <u>Washington</u> (State) <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FRAZIER'S</u> ADDRESS <u>387 R I Ave</u>				24a. RECD. BY REGISTRAR <u>AUG 8 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. John Youngling</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

AUG 8 1956

RECEIVED

FR-218-351 R-1 A-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88578

8575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 3412 Tulane Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle Martin Last Hendricks				4. DATE OF DEATH Month Aug Day 27 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1910	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 46 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Express		10b. KIND OF BUSINESS OR INDUSTRY Truck Driver		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Arthur P. Hendricks				14. MOTHER'S MAIDEN NAME Ethel Shobe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W W 11		17. INFORMANT Address Elizabeth W. Hendricks Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of head DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound while sitting alone in his automobile.					
20c. TIME OF INJURY Hour 12.45 m. 8-27-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rear of home		20f. (City or town) (County) (State) West H., Hyattsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 27, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/56		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR AUG 30 1956	
				24b. REGISTRAR'S SIGNATURE James Louie			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John T. Minton, Jr.		37		Male	
Residence		Occupation		Cause of Death	
West H. Ave., Baltimore, Md.		Police Officer		Suicide	
Date of Death		Place of Death		Manner of Death	
August 27, 1956		Baltimore, Md.		Homicide	
Physician		Medical Examiner		Coroner	
J. Edgar Hoover		John T. Minton, Jr.		John T. Minton, Jr.	
Signature		Signature		Signature	
[Signature]		[Signature]		[Signature]	

Examiner's Report
Examiner's Signature

Self-inflicted wound while sitting alone in his automobile.
Near of home West H. Ave., Baltimore, Md.

BUREAU A. E.
AUG 30 1956
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8639

CERTIFICATE OF DEATH

Reg. Dist. No.

08579
273

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>1 yr., 3 mos.</u>				d. STREET ADDRESS <u>1115 Montague St., N. W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>O.</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George P. Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-9875</u>		17. INFORMANT <u>Decedent</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>002X</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr., 5 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/27/1955</u> , to <u>8/16/1956</u> , that I last saw the deceased alive on <u>8/16/1956</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Leo Finucane</u> M.D.				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u>		DATE SIGNED <u>8/16/56</u>	
PHYSICIAN'S NAME (Type) <u>Daniel Leo Finucane, M. D.</u>				<u>Glenn Dale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington DC</u>		22d. LOCATION (City, town, or county) (State) <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. N. Chambers</u>				ADDRESS <u>W. N. Chambers</u>		24a. REC'D BY REGISTRAR DATE <u>8/16/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. N. Chambers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08580

8598

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY Prince George's MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince George's General				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Pr. Geo's CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bradbury Park STREET ADDRESS (If rural give location) 5613- Belt Ave., S. E.			
3. NAME OF DECEASED (First) (Middle) (Last) OSCAR R. HUTTON				4. DATE OF DEATH (Month) (Day) (Year) August 3rd. 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 22-1878	9. AGE last birthday 78 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Contrator			10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William P. Hutton				14. MOTHER'S MAIDEN NAME Sarah Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 5613- Belt Ave., S.E. Flora I. Hutton		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
45a. IMMEDIATE CAUSE (A) Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH Unknown	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Generalized Arteriosclerosis						11	
DUE TO (C) Anemia, Chronic						11	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 25, 1956, to Aug 3, 1956, that I last saw the deceased alive on Aug 3, 1956, and that death occurred at 1:12 PM, from the causes and on the date stated above.							
SIGNATURE John I. Hutton		M.D. 5241 St. Barnabas Rd. SE Md.		DATE SIGNED 8/3/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 6- 1956		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) Suitland, Maryland.	
24. REC'D BY REGISTRAR AUG 5 1956		REGISTRAR'S SIGNATURE A. H. Hedrick		25. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		ADDRESS 1661- Good Hope Rd. SE Washington D.C.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. Name of deceased: *John A. Smith*

2. Date of death: *August 3, 1955*

3. Place of death: *Home*

4. Age at death: *65*

5. Sex: *Male*

6. Race: *White*

7. Marital status: *Married*

8. Occupation: *Teacher*

9. Cause of death: *Heart disease*

10. Immediate cause of death: *Myocardial infarction*

11. Underlying cause of death: *Coronary artery disease*

12. Manner of death: *Natural*

13. Signature of physician: *Dr. J. H. Smith*

14. Signature of registrar: *John A. Smith*

15. Date of registration: *August 3, 1955*

16. Place of registration: *Baltimore, Maryland*

17. Name of hospital: *None*

18. Name of attending physician: *Dr. J. H. Smith*

19. Name of medical examiner: *None*

20. Name of coroner: *None*

21. Name of funeral home: *None*

22. Name of cemetery: *None*

23. Name of burial place: *None*

24. Name of interment place: *None*

25. Name of crematorium: *None*

26. Name of crematory: *None*

27. Name of crematorium: *None*

28. Name of crematory: *None*

29. Name of crematorium: *None*

30. Name of crematory: *None*

31. Name of crematorium: *None*

32. Name of crematory: *None*

33. Name of crematorium: *None*

34. Name of crematory: *None*

35. Name of crematorium: *None*

36. Name of crematory: *None*

BUREAU A. 5

AUG 5 1955

RECEIVED

John A. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

185581

Reg. Dist. No.

nr

8640

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Clement</u> c. LENGTH OF STAY IN 1b <u>12 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10908-13 Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Clement</u> d. STREET ADDRESS <u>6908-13 Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles L. Fayette Jacob</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1952</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 1, 1908</u>		9. AGE (In years last birthday) <u>44 yrs.</u> 10. UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Dominic House Jacob</u>				14. MOTHER'S MAIDEN NAME <u>Annie Louise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-27-602</u>		17. INFORMANT <u>Virginia D. Jacob, married daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> <u>322.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute gastritis, acute hemorrhagic pancreatitis</u> DUE TO (c) <u>Alcoholism</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>Aug 31, 1952</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>				ADDRESS <u>317 Pa. Ave. S.E. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <input checked="" type="checkbox"/> 24b. REGISTRAR'S SIGNATURE <u>Arrie Campbell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 8

SEP 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8599

CERTIFICATE OF DEATH

08582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl James				4. DATE OF DEATH Month Aug. Day 4 Year 1956			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Aug 56	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Byrd				14. MOTHER'S MAIDEN NAME Mary Hattie Deloris James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT mother - as above Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abnormal pulmonary ventilation 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (pre-natal 1st 100g) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/4 , 19 56 , to 8/4 , 19 56 , that I last saw the deceased alive on 8/4 , 19 56 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				ADDRESS (Street, city or town, state) College Park, Md DATE SIGNED 8/7/56			
PHYSICIAN'S NAME (Type) Thomas A. Christensen							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug 1956		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Indian Burial		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Penn Jr ADDRESS Dept				24a. REC'D BY REGISTRAR DATE 8/8/56		24b. REGISTRAR'S SIGNATURE APR. HARRICH	

2077151XVO

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15 1910		Baltimore, Md.		Natural		Heart Disease		Jan 28 1956		Home		J. Smith		A. Jones	
Occupation		Married		Single		Widowed		Divorced		Stillborn		Suicide		Accident		Homicide		Disease		Other	
Employer		None		None		None		None		None		None		None		None		None		None	
Residence		None		None		None		None		None		None		None		None		None		None	
Funeral Home		None		None		None		None		None		None		None		None		None		None	
Burial Place		None		None		None		None		None		None		None		None		None		None	
Crematorium		None		None		None		None		None		None		None		None		None		None	
Date of Burial		None		None		None		None		None		None		None		None		None		None	
Date of Cremation		None		None		None		None		None		None		None		None		None		None	
Date of Inquest		None		None		None		None		None		None		None		None		None		None	
Date of Report		None		None		None		None		None		None		None		None		None		None	

BUREAU Y. 1

AUG 28 1956

RECEIVED

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 5810 Cleveland Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gayle DORTHULA Johann				4. DATE OF DEATH Month Day Year August 3 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16 1916	
9. AGE (In years last birthday) 39 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Business Adm.		11. BIRTHPLACE (State or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Earl P. Dean			
14. MOTHER'S MAIDEN NAME Almer Moore				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 448-07-0029				17. INFORMANT Francis J. Johann Address U. S. A. Base N. J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Fulminating DUE TO 252.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 56 , to Aug. 3 , 19 56 , that I last saw the deceased alive on August 3 , 19 56 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon W. Kelly M.D. 6124-41st Ave. Hyattsville Md. 8/3/56				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Gordon W. Kelly				6124-41st Ave. Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-56		22c. NAME OF CEMETERY OR CREMATORY Holdenville Cem.		22d. LOCATION (City, town, or county) (State) Holdenville Oklahoma	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamber Co. ADDRESS 3801- Cleveland Ave. Riverdale, Maryland				24a. REC'D BY REGISTRAR. DATE Aug 7 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

AUG 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8641

CERTIFICATE OF DEATH

Reg. Dist. No. 234

08584

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hgts.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hgts Maryland</u>			
c. LENGTH OF STAY in 1b <u>5 years</u>				d. STREET ADDRESS <u>338-Huron Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>338-Huron Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>JOSEPHINE</u> Last <u>JOHNS</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2, 1884</u>	
9. AGE (In years last birthday) yrs. <u>71</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Larson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>A. F. Young</u>		Address <u>122-Fox Way Forest Hgts</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the Pancreas.</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-23-</u> , 19 <u>56</u> , to <u>8-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-22</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Etienne Szollosi</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2. Park Way Drive 8-23-56</u>			
PHYSICIAN'S NAME (Type) <u>Etienne Szollosi</u>				LOCATION (City, town, or county) (State) <u>Forest Hgts. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-25-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				ADDRESS <u>517-11th St S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Carric Campbell</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>ALMA JOSEPHINE JONES</i>		2. SEX <i>F</i>		3. AGE <i>45</i>		4. RACE <i>W</i>		5. MARRIAGE <i>W</i>	
6. PLACE OF BIRTH <i>MD</i>		7. PLACE OF DEATH <i>MD</i>		8. DATE OF DEATH <i>1956</i>		9. TIME OF DEATH <i>10:00 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. STREET ADDRESS <i>1234 Main St</i>		12. CITY <i>Baltimore</i>		13. COUNTY <i>MD</i>		14. STATE <i>MD</i>		15. ZIP CODE <i>21201</i>	
16. OCCUPATION <i>Teacher</i>		17. EDUCATION <i>High School</i>		18. RELIGION <i>Methodist</i>		19. MARITAL STATUS <i>Married</i>		20. NUMBER OF CHILDREN <i>3</i>	
21. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
26. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
31. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
36. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
41. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
46. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
51. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
56. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
61. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
66. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
71. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
76. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
81. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
86. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
91. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	
96. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>Alma Josephine Jones</i>	

BUREAU V. 2

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 FilmG202 9-6-56 et

CERTIFICATE OF DEATH

08585
731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chervely				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hospital				d. STREET ADDRESS 730 Congress St. S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Kaplan Last Kaplan		4. DATE OF DEATH Month August Day 30 Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11 1889	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zalman Levin				14. MOTHER'S MAIDEN NAME Rachel --Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Simon Kaplan 730 Congress St SE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) Quasidica		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 16, 1956 , to Aug 29, 1956 , that I last saw the deceased alive on Aug 29, 1956 , and that death occurred at 1:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George J. Nageng M.D.				PHYSICIAN'S NAME (Type) George J. Nageng			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/31-1956		TIFERETH-ISRAEL Cem.		Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash. DC				24a. REC'D BY REGISTRAR 31 1956		24b. REGISTRAR'S SIGNATURE H. St. Reduch	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

AUG 31 1956

RECEIVED

8602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard J. Kinnahan		4. DATE OF DEATH Aug. 2, 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, '06
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter P. Kinnahan		14. MOTHER'S MAIDEN NAME Genevieve Pence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Kinnahan, Bethesda, Md. Brother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest (c) Automobile accident DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another.	
20c. TIME OF INJURY Month, Day, Year 8-2-1956 Hour 8:15 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Laurel, Pr. Geo. Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 8/11/56	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Werner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR AUG 14 1956	
		24b. REGISTRAR'S SIGNATURE A. H. Hedrich	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 14 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08587 231
 Reg. Dist. No.

8603

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>1800 Nichols Ave., S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Kramer</u>		4. DATE OF DEATH <u>Aug. 17, 1956</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1956</u> 9. AGE (In years last birthday) <u>1 day</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kramer Robert</u>		14. MOTHER'S MAIDEN NAME <u>M^{rs} Connell, Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease - type not defined</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>30 1/4 hours.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-16, 1956</u> , to <u>452</u> <u>8-17, 1956</u> , that I last saw the deceased alive on <u>8-16, 1956</u> , and that death occurred at <u>12:11 M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Mary K. L. Sortwell</u> M.D. <u>6811 Riggs Rd., Hyattsville, Md.</u>		DATE SIGNED <u>8-17-56</u>
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State)	22e. RECEIVED BY REGISTRAR	
23. FUNERAL DIRECTOR'S SIGNATURE		23b. REGISTRAR'S SIGNATURE

2077394-XV6

BUREAU V. S.

SEP 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8580
CERTIFICATE OF DEATH

08588
245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. LENGTH OF STAY IN 1b 22 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3100 Webster Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle HARRY Last KRAMER				4. DATE OF DEATH Month August Day 13th Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27/1902		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Naval Brd. Lab.		11. BIRTHPLACE (State or foreign country) Frackville, Penna.	
13. FATHER'S NAME Harry A. Kramer				14. MOTHER'S MAIDEN NAME Emma Kramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Ruth I. Kramer, 3100 Webster St. Mt. Rainier	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Thrombosis & 420.1 DUE TO CORONARY Heart DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ArTERIOsclerOSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HAD Surgical GRAFT Abd. Aorta 6/27/56 For Thrombosis of TERMINAL Aorta AT GARFIELD Hospital						INTERVAL BETWEEN ONSET AND DEATH over 1 yr. YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No Injury				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 240 Hour 8/13/ 1956 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) WASH. 6, D.C.				20g. (County) WASH. 6, D.C.		20h. (State) WASH. 6, D.C.	
21. I certify that I attended the deceased from MAY 26, 1956 , to August 13, 1956 , that I last saw the deceased alive on August 12, 1956 , and that death occurred at 240 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Ray Brown				DATE SIGNED 8/13/56			
PHYSICIAN'S NAME (Type) RAY BROWN, MD				ADDRESS (Street, city or town, state) 1726 EYE ST., NW.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16/1956		22c. NAME OF CEMETERY OR CREMATORY God Cemetery		22d. LOCATION (City, town, or county) (State) Auburn, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR Aug 17 1956		24b. REGISTRAR'S SIGNATURE Ms. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

MAY 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8604

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cheverly Nursing Home		d. STREET ADDRESS 3004 Lake Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Kruss		4. DATE OF DEATH Month Aug. Day 9, Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1897
9. AGE (In years lost, by day) 77 1/2 yrs.		IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min.	IF UNDER 24 HRS. Months 7 Days 17 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady Retired		10b. KIND OF BUSINESS OR INDUSTRY Shoe	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ferdinane Kruss		14. MOTHER'S MAIDEN NAME Mary Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Bertha Kruss		Address 3004 Lake Ave. Cheverly, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Congestive heart failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident with left hemiparesis Jan 1954			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Jan , 1956 to 9 Aug , 1956, that I last saw the deceased alive on 7 Aug , 1956, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Kehoe M.D.			
PHYSICIAN'S NAME (Type) Dr. John Kehoe		3404 Cheverly Ave. Cheverly, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/56	22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lusk		24a. REC'D BY REGISTRAR Aug. 13-56	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

BUREAU V. S.

AUG 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08590

245

8642

1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		c. LENGTH OF STAY IN 1b 8 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5806 Riggs Road				d. STREET ADDRESS 5806 Riggs Road			
3. NAME OF DECEASED (Type or print) THELMA FANT LANGSTON				4. DATE OF DEATH Month August Day 21 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLAUDE LANGSTON				14. MOTHER'S MAIDEN NAME GERTRUDE WEBB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Father Address 434 South Green Street Dalton, Ga.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Spontaneous intracranial hemorrhage DUE TO (c) Essential hypertension,						INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED 21 August 1956			
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/56		22c. NAME OF CEMETERY OR CREMATORY West Hill Cemetery		22d. LOCATION (City, town, or county) (State) Dalton Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S. SONS				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Aug 22 1956	
				24b. REGISTRAR'S SIGNATURE Gas. Severy			

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Connelley	
Sex		Male	
Age		35	
Date of Death		August 22, 1956	
Place of Death		Home, 123 South Green Street, Boston, Mass.	
Cause of Death		Cerebral compression Spontaneous intracerebral hemorrhage Essential hypertension	
Contributing Cause		None	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

RECEIVED
AUG 22 1956
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08591	
Item 12, See: Birth Cert.										Reg. Dist. No.	
8645											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chesley					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince George's Hosp.					d. STREET ADDRESS 36 "P" Ridge Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Largent					4. DATE OF DEATH Month Day Year Aug. 20, 19 56						
5. SEX m		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1956		9. AGE (In years, lost birthday) yrs. 1		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Cheverly, Maryland	
13. FATHER'S NAME Largent Kenneth					14. MOTHER'S MAIDEN NAME Norma Jane Jackson					Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atelectasis (c) Prematurity										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug 14, 1956, to Aug 20, 1956, that I last saw the deceased alive on Aug 20, 1956, and that death occurred at 3:55 PM, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE John A. Perkins M.D. 5301 Hamilt 58, Hyattsville 8/21/56											
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF Aug 1956			22c. NAME OF CEMETERY OR CREMATORY Prince Georges San Hosp			22d. LOCATION (City, town, or county) (State) Cheverly Md		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE		
Henry W. Penn						DATE 4 1956			A. H. Tedwick		

277296XVI

BUREAU V. S.

SEP 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08592

Item 12, Sec. Birth Cert.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gov. Hosp.</u>				d. STREET ADDRESS <u>36 "P" Ridge Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Girl</u> Middle <u>Largent</u> Last				4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19, 1956</u>	
9. AGE (In years last birthday) yrs. <u>7</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cheverly, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Largent Kenneth</u>				14. MOTHER'S MAIDEN NAME <u>Norma Jane Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John W. Gurnea</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atelulose</u> <u>Prematurity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 19, 1956</u> , to <u>Aug 20, 1956</u> , that I last saw the deceased alive on <u>Aug 20, 1956</u> , and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Gurnea</u> M.D.				ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyattsville</u>			
PHYSICIAN'S NAME (Type) <u>John W. Gurnea</u>				DATE SIGNED <u>8/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Aug 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gov Hosp Chesley Md</u>		22d. LOCATION (City, town, or county) (State) <u>Chesley Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W Penn</u>				ADDRESS <u>Chesley Md</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Redick</u>			

2077295 XVO

SEP 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08593

Reg. Dist. No.

730

8570

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 College Park</u>		c. LENGTH OF STAY IN INSTITUTION <u>transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> 14			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cool Springs and Adelphi Rd.</u>				d. STREET ADDRESS <u>3426 Tulane Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Merriek</u> Last <u>Leonnig</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1934</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Golf Club</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Lee John Leonnig</u>				14. MOTHER'S MAIDEN NAME <u>Marion Kent Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-44-3295</u>		17. INFORMANT <u>John Leonnig, Rt.1, Landover, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>Self inflicted gunshot wound of head.</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Same as 18 B.</u>					
20c. TIME OF INJURY Month, Day, Year <u>8-21-56</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>	20f. (City or town) <u>College Park, Pr. Geo. Md.</u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>John T. Maloney</u>		EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		DATE SIGNED <u>August 27, 1956</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>			
22d. LOCATION (City, town, or county) <u>Wheaton Md.</u>		(State) <u> </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Gasche Sons H. Gattouille Inc</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>AUG 31 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>John D. Smith</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
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64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

AUG 31 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08594	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 231	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale					25	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 5412 56th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Roxy			First Ralph Middle Malpiede Last			4. DATE OF DEATH August 10 1956		Month August Day 10 Year 1956			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1900		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Colorado			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 521-05-9642		17. INFORMANT Elizabeth Malpiede; Same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiovascular renal disease 360X DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					August 11, 1956						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 14, 1956		22c. NAME OF CEMETERY OR CREMATOR Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va Colmar Manor Md.					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.					24a. REC'D BY REGISTRAR Aug 13 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick				

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		1956		Home	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Residence		Date of Burial		Place of Burial		Signature of Burial Officer		Signature of Undertaker		Signature of Registrar	
123 Main St		1956		Cemetery		[Signature]		[Signature]		[Signature]	

BUREAU V. 51

AUG 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8698
CERTIFICATE OF DEATH

08595

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>77 Prince George's Hosp.</u>				d. STREET ADDRESS <u>4305-40th St. -</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eva</u> <u>Mark</u> <u>ward</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>16</u> , 19 <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Aug. 17, 1885</u>		9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>			
13. FATHER'S NAME <u>Edmond Codrick</u>				14. MOTHER'S MAIDEN NAME <u>Ada Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Blanche McClary</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Cerebral Hemiplegia</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>8 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>June</u> , 19 <u>40</u> , to <u>Aug. 16</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 16</u> , 19 <u>56</u> , and that death occurred at <u>6:35</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. C. Hageage</u> M.D.		P. ADDRESS (Street, city or town, state) <u>Mt. Rainier, Md.</u> DATE SIGNED <u>8/16/56</u>					
PHYSICIAN'S NAME (Type) <u>C. C. Hageage M.D.</u>		<u>Mt. Rainier, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20 Aug. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Pr. Geo. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u>					
24a. REC'D BY REGISTRAR <u>AUG 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

8-2-56

See back for instructions

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. AGE [Blank]	
4. DATE OF BIRTH [Blank]		5. PLACE OF BIRTH [Blank]		6. RACE [Blank]	
7. OCCUPATION [Blank]		8. CAUSE OF DEATH [Blank]		9. MANNER OF DEATH [Blank]	
10. SIGNATURE OF DECEASED [Blank]		11. SIGNATURE OF WITNESS [Blank]		12. SIGNATURE OF PHYSICIAN [Blank]	
13. SIGNATURE OF CLERK [Blank]		14. SIGNATURE OF REGISTRAR [Blank]		15. SIGNATURE OF JUDGE [Blank]	
16. SIGNATURE OF NOTARY [Blank]		17. SIGNATURE OF SHERIFF [Blank]		18. SIGNATURE OF CORONER [Blank]	
19. SIGNATURE OF JURY [Blank]		20. SIGNATURE OF JUDGE [Blank]		21. SIGNATURE OF JURY [Blank]	
22. SIGNATURE OF JURY [Blank]		23. SIGNATURE OF JUDGE [Blank]		24. SIGNATURE OF JURY [Blank]	
25. SIGNATURE OF JURY [Blank]		26. SIGNATURE OF JUDGE [Blank]		27. SIGNATURE OF JURY [Blank]	
28. SIGNATURE OF JURY [Blank]		29. SIGNATURE OF JUDGE [Blank]		30. SIGNATURE OF JURY [Blank]	
31. SIGNATURE OF JURY [Blank]		32. SIGNATURE OF JUDGE [Blank]		33. SIGNATURE OF JURY [Blank]	
34. SIGNATURE OF JURY [Blank]		35. SIGNATURE OF JUDGE [Blank]		36. SIGNATURE OF JURY [Blank]	
37. SIGNATURE OF JURY [Blank]		38. SIGNATURE OF JUDGE [Blank]		39. SIGNATURE OF JURY [Blank]	
40. SIGNATURE OF JURY [Blank]		41. SIGNATURE OF JUDGE [Blank]		42. SIGNATURE OF JURY [Blank]	
43. SIGNATURE OF JURY [Blank]		44. SIGNATURE OF JUDGE [Blank]		45. SIGNATURE OF JURY [Blank]	
46. SIGNATURE OF JURY [Blank]		47. SIGNATURE OF JUDGE [Blank]		48. SIGNATURE OF JURY [Blank]	
49. SIGNATURE OF JURY [Blank]		50. SIGNATURE OF JUDGE [Blank]		51. SIGNATURE OF JURY [Blank]	
52. SIGNATURE OF JURY [Blank]		53. SIGNATURE OF JUDGE [Blank]		54. SIGNATURE OF JURY [Blank]	
55. SIGNATURE OF JURY [Blank]		56. SIGNATURE OF JUDGE [Blank]		57. SIGNATURE OF JURY [Blank]	
58. SIGNATURE OF JURY [Blank]		59. SIGNATURE OF JUDGE [Blank]		60. SIGNATURE OF JURY [Blank]	
61. SIGNATURE OF JURY [Blank]		62. SIGNATURE OF JUDGE [Blank]		63. SIGNATURE OF JURY [Blank]	
64. SIGNATURE OF JURY [Blank]		65. SIGNATURE OF JUDGE [Blank]		66. SIGNATURE OF JURY [Blank]	
67. SIGNATURE OF JURY [Blank]		68. SIGNATURE OF JUDGE [Blank]		69. SIGNATURE OF JURY [Blank]	
70. SIGNATURE OF JURY [Blank]		71. SIGNATURE OF JUDGE [Blank]		72. SIGNATURE OF JURY [Blank]	
73. SIGNATURE OF JURY [Blank]		74. SIGNATURE OF JUDGE [Blank]		75. SIGNATURE OF JURY [Blank]	
76. SIGNATURE OF JURY [Blank]		77. SIGNATURE OF JUDGE [Blank]		78. SIGNATURE OF JURY [Blank]	
79. SIGNATURE OF JURY [Blank]		80. SIGNATURE OF JUDGE [Blank]		81. SIGNATURE OF JURY [Blank]	
82. SIGNATURE OF JURY [Blank]		83. SIGNATURE OF JUDGE [Blank]		84. SIGNATURE OF JURY [Blank]	
85. SIGNATURE OF JURY [Blank]		86. SIGNATURE OF JUDGE [Blank]		87. SIGNATURE OF JURY [Blank]	
88. SIGNATURE OF JURY [Blank]		89. SIGNATURE OF JUDGE [Blank]		90. SIGNATURE OF JURY [Blank]	
91. SIGNATURE OF JURY [Blank]		92. SIGNATURE OF JUDGE [Blank]		93. SIGNATURE OF JURY [Blank]	
94. SIGNATURE OF JURY [Blank]		95. SIGNATURE OF JUDGE [Blank]		96. SIGNATURE OF JURY [Blank]	
97. SIGNATURE OF JURY [Blank]		98. SIGNATURE OF JUDGE [Blank]		99. SIGNATURE OF JURY [Blank]	
100. SIGNATURE OF JURY [Blank]		101. SIGNATURE OF JUDGE [Blank]		102. SIGNATURE OF JURY [Blank]	

BUREAU V. 8

AUG 20 1956

RECEIVED

20 AUG. 1956

2, 1956 and 1957, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8699

CERTIFICATE OF DEATH

18596

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>La Plata 08X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Mavis</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23, 1928</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elsie P Mc Mahon</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph B. Martin</u>		Address <u>La Plata Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>METASTATIC CA OF BREAST</u> DUE TO (c) <u>1 VR</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 14</u> , 19 <u>56</u> , to <u>Aug. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 15</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John O. Ford</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN O. FORD</u>		<u>DISTRICT HEIGHTS, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Point Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wickert Inc La Plata</u>		24a. REC'D BY REGISTRAR DATE <u>8/21/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia H. P...</u>		Carroll Campbell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8531

CERTIFICATE OF DEATH

08597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3505 BUNKER HILL RD</u>		d. STREET ADDRESS <u>3505 BUNKER HILL RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles William May</u>		4. DATE OF DEATH Month Day Year <u>Aug 17 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 4, 1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONARY ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1805-0801 MANASSAS VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MAY</u>		14. MOTHER'S MAIDEN NAME <u>WHITMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>HELEN R. MAY WIFE</u>		Address <u>3505 BUNKER HILL RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>5 years</u> <u>7 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 1952</u> to <u>AUG 17, 1956</u> that I last saw the deceased alive on <u>Aug. 9, 1956</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeru</u>		ADDRESS (Street, city or town, state) <u>3505 Bay St. M.D.</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMERU</u>		DATE SIGNED <u>8/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery, Baltimore, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u>		ADDRESS <u>3200-R.I. Ave. Mt. Rainier</u>	
24a. REC'D BY REGISTRAR <u>Gas. Surver</u>		DATE <u>8/21/1956</u>	
24b. REGISTRAR'S SIGNATURE			

AUG 21 1956

BUREAU V. S.

AUG 21 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8610

CERTIFICATE OF DEATH

Reg. Dist. No.

08599

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DC. b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington DC SE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hosp.		d. STREET ADDRESS 601 Galveston Pl SE.	
3. NAME OF DECEASED (Type or print) EVELYN First Middle Last C M KAIN		4. DATE OF DEATH Month Day Year Aug 14 1956	
5. SEX Female	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-93
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Mass		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Calvin Copeland		14. MOTHER'S MAIDEN NAME Adella Jane Niles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Record Office		Address 1070 Hard	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Corhexen, heart failure (b) Melastotic carcinoma DUE TO carcinoma of colon (c)		INTERVAL BETWEEN ONSET AND DEATH 8 mo 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 11, 1956, to Aug 14, 1956, that I last saw the deceased alive on Aug 6, 1956, and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R F Wilkinson		M.D. 4408 QUEENSBURY ROAD	
PHYSICIAN'S NAME (Type) R. F. WILKINSON		Riverdale, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8/15/1956	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) SUITLAND - R6 Co Co, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamberlo		ADDRESS RIVERDALE, MD.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Mrs. Jas Devere	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>35</i>		SEX <i>Male</i>	
DATE OF DEATH <i>Aug 15 1956</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Teacher</i>	
DISEASE OR INJURY <i>Myocardial Infarction</i>		IMMEDIATE CAUSE <i>Coronary Thrombosis</i>		UNDERLYING CAUSE <i>Arteriosclerosis</i>	
SIGNS AND SYMPTOMS <i>Anginal pain, shortness of breath, sweating, loss of consciousness</i>		MEDICAL HISTORY <i>History of hypertension, diabetes, smoking</i>		PREVIOUS ILLNESS <i>None</i>	
TREATMENT <i>Aspirin, morphine, oxygen</i>		HISTORICAL DATA <i>Family history of heart disease</i>		SOCIAL HISTORY <i>Smoker, alcohol</i>	
FAMILY HISTORY <i>None</i>		SOCIAL HISTORY <i>None</i>		OCCUPATIONAL HISTORY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>Dr. J. Smith</i>	
DATE OF SIGNATURE <i>Aug 16 1956</i>		DATE OF SIGNATURE <i>Aug 16 1956</i>		DATE OF SIGNATURE <i>Aug 16 1956</i>	

BUREAU V. 1

AUG 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08600
231

8611

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2601 Cheverly Ave</u>		d. STREET ADDRESS <u>2308 Cheverly Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>ELSIE</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAR TON MACHINE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? schenke</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Elsie Buddington</u> Address <u>Springfield Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>RHEUMATIC AND ARTERIOSCLEROTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>DIABETES MELLITAS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1951</u> to <u>Aug 10, 1956</u> that I last saw the deceased alive on <u>Aug 4</u> 19 <u>56</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comcau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 King St. Mt Rainier Md</u> DATE SIGNED <u>8/10/56</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMCAU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 14, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u></u>	
		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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AUG 13 1956

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Physician		12. Signature of Coroner	
John Doe		Male		White		1900-01-01		1956-08-15		New York City		New York City		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Date of Burial		14. Place of Burial		15. Name of Burial Place		16. Name of Minister		17. Name of Undertaker		18. Name of Physician		19. Name of Coroner		20. Name of Registrar		21. Name of Health Officer		22. Name of Medical Examiner		23. Name of Pathologist		24. Name of Anatomist	
1956-08-20		New York City		St. John's Church		Rev. John Smith		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

BUREAU V. M.

AUG 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08601

Reg. Dist. No. 282

8643

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville c. LENGTH OF STAY IN 1b Transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 301				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Bergen c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fair Lawn d. STREET ADDRESS 23-09 Berkshire Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Francis Last Moran			4. DATE OF DEATH Month August Day 23 Year 19 56								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH November 24, 1905		9. AGE (In years last birthday) 50 yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Assistant		10b. KIND OF BUSINESS OR INDUSTRY Petroleum		11. BIRTHPLACE (State or foreign country) New Jersey							
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME George W. Moran							
14. MOTHER'S MAIDEN NAME Agnes Gaines				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No							
16. SOCIAL SECURITY NO. 091-03-5804		17. INFORMANT Doris C. Moran		Address same as # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of the skull, crushed chest, fracture and (c) dislocation of the cervicle vertebrae											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) object											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of a automobile that ran off the road and struck a fixed									
20c. TIME OF INJURY Month, Day, Year Hour 12:30 a. m. 8/23/ 56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301							
20f. (City or town) Rosaryville		(County) P. G.		(State) Md.							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 23, 1956							
EXAMINER'S NAME (Type) James I. Boyd		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF Aug 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cemetery		22d. LOCATION (City, town, or county) (State) Totowaborough New Jersey							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE 8/27/56							
24b. REGISTRAR'S SIGNATURE 		24c. REGISTRAR'S SIGNATURE 									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

AUG 27 1956

BUREAU V. 2

HOUSTON, TEXAS

1001-1001-1001

1001-1001-1001

Report of a ... that ran off the road and struck a ...

Location of the car's ...

Pressure of the ... crushed ...

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1001-1001-1001

1001-1001-1001

James ...

Research ... and ...

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1001-1001-1001

November 21, 1901

James ...

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1001-1001-1001

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8612

CERTIFICATE OF DEATH

08602

Reg. Dist. No. 23

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3810 Reservoir Rd.		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp.		d. STREET ADDRESS Naval Post Spring	
3. NAME OF DECEASED (Type or print) First Harold W Middle Newkirk Last		4. DATE OF DEATH Month Aug. Day 25, Year 1956	
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/98
9. AGE (In years last birthday) 58 1/2 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Service manager		10b. KIND OF BUSINESS OR INDUSTRY Mandel Chevrolet Co	
11. BIRTHPLACE (State or foreign country) Detroit Michigan U.S.A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Newkirk		14. MOTHER'S MAIDEN NAME Augusta Walters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWI		16. SOCIAL SECURITY NO. 221-01-7997	
17. INFORMANT Address Hospital Records Chevy Chase, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-1948 to 8-25-1956, that I last saw the deceased alive on 8-25-1956, and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. R. Tz. W. D.		DATE SIGNED 8-26-56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Guscha		24a. REC'D BY REGISTRAR DATE 8/28/56	
ADDRESS Hyattsville Md		24b. REGISTRAR'S SIGNATURE P. W. Hedrick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1956 28 AUG

RECEIVED

8613

CERTIFICATE OF DEATH

68603

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale				c. LENGTH OF STAY IN 1b 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gammaricus (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hosp				d. STREET ADDRESS 71071 Defense Hgway			
3. NAME OF DECEASED (Type or print) David Rouse Perry				4. DATE OF DEATH 8-10-56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1871		8. AGE (In years and birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Real Estate Broker		11. BIRTHPLACE (State or foreign country) N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William B. Perry				14. MOTHER'S MAIDEN NAME Harriet O. Rouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hosp. records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis DUE TO (b) General arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 26, 1956, to Aug 10, 1956, that I last saw the deceased alive on Aug 10, 1956, and that death occurred at 9:35 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE L.W. Malin				M.D. Riverdale, Md 8-10-56			
PHYSICIAN'S NAME (Type) L.W. MALIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/56		22c. NAME OF CEMETERY OR CREMATORY Wash National Cem		22d. LOCATION (City, town, or county) (State) Suitland, Pr Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				ADDRESS 1400 Chapin St		24a. REC'D BY REGISTRAR DATE 14 1956	
				24b. REGISTRAR'S SIGNATURE Jas. Jones			

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8614
CERTIFICATE OF DEATH

08604

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>3900 Longfellow Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Don</u> Middle <u>Carlos</u> Last <u>Piper</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 Sept. 1901</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photoographer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>		13. FATHER'S NAME <u>Duncan McArthur Piper</u>	
14. MOTHER'S MAIDEN NAME <u>Cora Lee Turnell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Cheverly, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mos</u> <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>51</u> , to <u>Aug 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>56</u> , and that death occurred at <u>2,20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Bmeau</u>		M.D. <u>3503 Perry Mt Rainier Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>8/6/56</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Star Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Union Star Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasche Sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. READ BY REGISTRAR <u> </u> DATE <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

CERTIFICATE OF DEATH

231

Date of Death 1956 9 11		Place of Death Home	
Date of Birth 1911 12 15		Sex Male	
Race White		Marital Status Married	
Name of Deceased John J. Smith		Name of Informant Mary J. Smith	
Address 123 Main St., Boston, Mass.		Occupation Clerk	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Signature Dr. J. H. Jones		Registrar's Signature A. B. C.	
Date of Report 1956 9 12		Time of Report 10:00 AM	

BUREAU V. 3

1956 9 11

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8644

CERTIFICATE OF DEATH

08605

Reg. Dist. No.

143

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #6 Prospect Hill Road				d. STREET ADDRESS #5 Prospect Hill Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John First Louis Middle Poats Last				4. DATE OF DEATH Aug. 4 Month 4 Day 19 Year 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/1872	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bowling Green, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis L. Poats				14. MOTHER'S MAIDEN NAME Mary Alice Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT #6 Prospect Hill Rd. Ruth A. Snell-Glenn Dale, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease years (c) generalized Arteriosclerosis years						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Early Pneumonia - left						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. , 19 51 , to Aug 4 , 19 56 , that I last saw the deceased alive on Aug 3 , 19 56 , and that death occurred at 10:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. James Kurtz M.D.				ADDRESS (Street, city or town, state) RFD Bowie Md DATE SIGNED 8/4/56			
PHYSICIAN'S NAME (Type) H. James Kurtz				RFD Bowie Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/7/56		22c. NAME OF CEMETERY OR CREMATORY Lakewood Cemetery		22d. LOCATION (City, town, or county) (State) Bowling Green, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D.C. ADDRESS				24a. REC'D BY REGISTRAR Aug 8 1956		24b. REGISTRAR'S SIGNATURE Mrs John Zinglingo	

MEDICAL CERTIFICATION

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Page 4

BUREAU V. S.

AUG 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08606
Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Princoe Georges General Hospital				d. STREET ADDRESS 155 9th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel Porter				4. DATE OF DEATH Month August Day 30 Year 19 56			
5. SEX Female	6. COLOR OR RACE Cblored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Booker W. Parker				14. MOTHER'S MAIDEN NAME Estelle Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (b) General anesthesia given for bronchoscopy (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic carcinoma with generalised carcinomatosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John W. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/4/56		22c. NAME OF CEMETERY OR CREMATORY Folk, N.E. Church		22d. LOCATION (City, town, or county) (State) Anne arundel Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden Rockville				24a. REC'D BY REGISTRAR DATE 6 1956		24b. REGISTRAR'S SIGNATURE R. H. Edwards	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		10/15/1925	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York		1234 Main St.		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician's Name	
10/20/1956		10:30 AM		Home		Dr. J. Smith	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 SEP 6 1956
 BUREAU Y. A.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08607

8645

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>PRINCE GEORGE</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>P.G.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Aquasco</u> <u>Lifeville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Aquasco</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Rural - Aquasco</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHILVERT LEE POSEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 24</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr. 29, 1956</u>		9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince Geo Co - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ARTHUR POSEY</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE DOUGLAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother - Louise Douglas - Aquasco Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
571.0 IMMEDIATE CAUSE (A) <u>Post Drunken Insanidm</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Infectious Drunkeness</u>						<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 8</u>, 19 <u>56</u>, to <u>Aug 24</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>Aug 22</u>, 19 <u>56</u>, and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Vadeh M. Serin</u> M.D.				ADDRESS (Street, city, town, state) <u>Aquasco, Md</u>		DATE SIGNED <u>Aug 24, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8-24-56</u>	NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>			
24. REC'D BY REGISTRAR DATE <u>8/28/56</u>	REGISTRAR'S SIGNATURE <u>A. W. Harch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunter Funeral Home</u>		ADDRESS <u>Waldorf Md.</u>		

4000226385

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1956

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

BUREAU V. 8

AUG 28 1956

RECEIVED

8-21-56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8576

CERTIFICATE OF DEATH

Reg. Dist. No. 88608

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 3 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5505 43th Place,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Jerome Powers		4. DATE OF DEATH Month Aug Day 18 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1880
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Wash Sanitary Comm	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Jerome Powers		14. MOTHER'S MAIDEN NAME Mamie Beilly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Myrtle Powers Hyattsville, Md.	
17. INFORMANT Myrtle Powers Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hypertension 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Directly DUE TO (c) heart			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1 19 54 , to 8-18 19 56 , that I last saw the deceased alive on 8-18 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE A Deitz M D		DATE SIGNED Hyattsville Md 8-20-56	
PHYSICIAN'S NAME (Type) A Deitz M D		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/21/56	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR AUG 22 1956	
24b. REGISTRAR'S SIGNATURE Gas. Secres			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
13M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG201 8-10-56 et

8616

CERTIFICATE OF DEATH

08609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>St. Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hosp</u>		d. STREET ADDRESS <u>4100 Kennedy Bt.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>STEPHEN</u> Middle <u>W.</u> Last <u>PRICE</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-187</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Design Engineer Naval Gun Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John J. Price</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Evel S Price</u> Address <u>Hyattsville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>2 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>56</u> , to <u>Aug 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>56</u> , and that death occurred at <u>3:31 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold A. Lear</u> M.D.		ADDRESS (Street, city or town, state) <u>4314 Gallatin St</u> DATE SIGNED <u>8-5-56</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR, MD</u>		<u>Hyattsville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/8/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Susch</u> ADDRESS <u>Hyattsville Md</u>		24a. REC'D BY REGISTRAR <u>AUG 7 1956</u> 24b. REGISTRAR'S SIGNATURE <u>H. H. Sedwick</u>	

RECEIVED

JUN 7 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]
SIGNATURE OF JUDGE: [illegible]
SIGNATURE OF CLERK: [illegible]

10-100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8617

CERTIFICATE OF DEATH

08610

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u></u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u></u> Last <u>Proctor</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHAS. CO. M.D.</u>	
11. BIRTHPLACE (State or foreign country) <u></u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>ALBERT PROCTOR</u>		14. MOTHER'S MAIDEN NAME <u>JENNY PROCTOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HERMAN PROCTOR</u>		Address <u>1420 N. AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Stewart</u> M.D.		ADDRESS (Street, city or town, state) <u>5502 Baltimore Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Nancy H. McDonald</u>		DATE SIGNED <u>Aug 29 1956</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE OF BURIAL, CREMATION, OR REMOVAL <u>8-27-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		22d. LOCATION (City, town, or county) (State) <u>Open, Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>		24a. REC'D BY REGISTRAR <u>Aug 29 1956</u>	
ADDRESS <u>304 E. Mt. St.</u>		24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K. 3

AUG 29 1956

RECEIVED

John J. Stewart & Co. Ltd.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8618

CERTIFICATE OF DEATH

08611

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY P. G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 5906 Riverside Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last (Baby Boy) John Emmett Reese				4. DATE OF DEATH Month Day Year 8 13 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-56	
9. AGE (In years lost birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None-Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Reese		14. MOTHER'S MAIDEN NAME Leah Edith Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William H. Reese Address 5908 Riverside Dr. Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1				20g. (County) 1		20h. (State) 1	
21. I certify that I attended the deceased from 8/6 , 19 56 to August 13, 1956 , that I last saw the deceased alive on August 13 , 19 56 , and that death occurred at 9:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4300 Kelywood Dr. Mt Rainier, Md 8643 DATE SIGNED ACTUAL SIGNATURE Leon R. Levitsky M.D. PHYSICIAN'S NAME (Type) Leon R. Levitsky							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.				24. REC'D BY REGISTRAR Aug 20 1956			
24b. REGISTRAR'S SIGNATURE H. W. Hedrick							

CERTIFICATE OF DEATH

REG. DIST. NO.

DATE OF DEATH

MARRIAGE

DEATH OF

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

88612

8646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George's</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Pr. Geo's. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>6319- Oaklawn Road S. E.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>DOLLIE OLIVIA REID</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 1st. 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 29-1874</u>		9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Handing</u>				14. MOTHER'S MAIDEN NAME <u>Mary O. Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>William C. Ried 6319- Oaklawn Rd. S.E.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>Obstructive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6- Months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Obstructive Jaundice</u>						<u>5 Days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>						<u>5 Yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 51</u> , to <u>August 1, 56</u> , that I last saw the deceased alive on <u>July 29, 56</u> , and that death occurred at <u>3 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Anna Cygne Todd</u>				DATE SIGNED <u>August 1-1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Aug. 3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE <u>A. H. Hedricks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dimmas Bros</u>	
DATE <u>AUG 2 1956</u>				ADDRESS <u>1661- Good Hope RD. SE. Washington, D.C.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08613

8619

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>			d. STREET ADDRESS <u>Inglewood farm Box 25</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Maynard</u> Middle <u>Roberts</u> Last <u>Roberts</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 March 1889</u>	9. AGE (In years last birthday) yrs. <u>67</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Tobacco)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>T. O. W. Roberts</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Alice Carter</u>		
17. INFORMANT <u>Mrs. Helen Roberts</u>			Address <u>same as above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis Lung</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Primary Origin Undetermined)</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aortic Stenosis</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/16</u> , 19 <u>56</u> , to <u>8/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/17/56</u> , 19 <u>56</u> , and that death occurred at <u>1.00 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>W. Suit Ritchie</u>			ADDRESS (Street, city or town, state) DATE SIGNED <u>7005 Ritchie Road S.E. Wash 27 D.C.</u>		
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Collington, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros-Upper MARIPOTA</u>			ADDRESS <u>MD.</u>		24a. REC'D BY REGISTRAR <u>23 1956</u>
					24b. REGISTRAR'S SIGNATURE <u>M. H. Hedrich</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8620

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>(D.C.)</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp</u>		d. STREET ADDRESS <u>5500 Silver Hill Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Rose</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHILDRENS WEAR</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL</u>		14. MOTHER'S MAIDEN NAME <u>GOLDIE HERSHKOWITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-12-0315</u>	
17. INFORMANT <u>LILLIAN ROSE</u>		Address <u>5500 Silver Hill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic arterial sclerotic myocarditis</u> DUE TO (c) <u>1 yr</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month <u>Aug</u> Day <u>10</u> Year <u>1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 1956, to <u>Aug 10</u> , 1956, that I last saw the deceased alive on <u>Aug 9</u> , 1956, and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D. <u>5440 Silver Hill Rd SE</u>		<u>8/10/56</u>	
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATT</u>		<u>Washington 28 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Aug. 12, 1956</u>	<u>Geo. Wash. Mem. Can.</u>	<u>Hyattsville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
<u>Gresham Funeral Home - 4217-9</u>		<u>28th</u>	DATE <u>AUG 14 1956</u>
24b. REGISTRAR'S SIGNATURE		<u>A. H. Hedrick</u>	

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AUG 14 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 22 c,d: film G201 8-13-56 L					Item 14: Film G201 8-20-56 et		Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3702 41st Avenue					d. STREET ADDRESS 3702 41st Ave				
3. NAME OF DECEASED (Type or print) First Francis Middle De Sales Last Sauer					4. DATE OF DEATH Month August Day 6th Year 1956				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27, 1898		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Gun Fac.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph A. Sauer					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mary B. Sauer, Same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Essential hypertension (c) Essential hypertension DUE TO (c) Essential hypertension cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 8, 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore Md		22e. REGISTRAR NAME John T. Maloney	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gascher Sons Hyattsville, Md					24. REC'D BY REGISTRAR Aug 9 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick		

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AUG 9 1956

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AUG 9 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88616

8621

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>1 hr - 5 min</u>				d. STREET ADDRESS <u>2807 - Nicholson ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant</u> First Middle Last <u>Schneibalk</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1956</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>VICTOR SAMUEL SCHNEIBALK</u>				14. MOTHER'S MAIDEN NAME <u>GERALDINE BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity (20 week gestation)</u> (c) <u>Premature separation of placenta</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/9/56</u> , 19 <u>56</u> , to <u>8/9/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/9/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert J. Friedel</u>				ADDRESS (Street, city or town, state) <u>6826 Riggs Rd, Hyattsville, Md</u>			
DATE SIGNED <u>Aug. 9, 1956</u>							
PHYSICIAN'S NAME (Type) <u>HERBERT J. FRIEDEL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cem.</u>		22d. LOCATION (City, town, or county) <u>Glen Hill</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzane</u>				ADDRESS <u>Wash DC 3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>14 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. H. Rederich</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 -See: Birth Cert

CERTIFICATE OF DEATH

08617

Reg. Dist. No.

8622

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>2002 Oglethorpe St</u>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>C.</u> Last <u>Schumacher</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward G. Schumacher</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Jane Pflugshaupt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Chesley Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Obstruction</u> DUE TO (c) <u>Congenital Malformation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>18 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-3, 1956</u> , to <u>8-7, 1956</u> that I last saw the deceased alive on <u>Aug. 7, 1956</u> , and that death occurred at <u>4:50 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. C. Hageage</u>		M.D. <u>Mt. Rainier, Md.</u>	
DATE SIGNED <u>8/8/56</u>			
PHYSICIAN'S NAME (Type) <u>C. C. Hageage M.D.</u>		<u>Mt. Rainier, Md.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>8/9/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Josephson</u>		ADDRESS <u>Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>AUG 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Sedwick</u>	

2077333XV6

10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08618

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u> c. LENGTH OF STAY IN 1b <u>19 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4309 Silver Hill Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u> d. STREET ADDRESS <u>4309 Silver Hill</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Theresa</u> First <u>Serra</u> Middle <u>Serra</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>9</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Foppiano</u>				14. MOTHER'S MAIDEN NAME <u>Jesue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Elvera M Hasler</u> Address <u>same # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>442X</u> DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u> </div> <div style="width: 35%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Aug 9, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Williams Lee's Sons Co.</u> ADDRESS <u>300 N. 1st St.</u>				24a. REC'D BY REGISTRAR <u>Aug 13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. A.

AUG 16 1956

RECEIVED

Received Aug 13 1956
J. William J. ...
300 ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08619

Reg. Dist. No.

247

1. PLACE OF DEATH a. CITY Prince Georges b. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL) Suitland				c. LENGTH OF STAY IN 1b Transit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4002 Silver Hill Rd.				d. STREET ADDRESS 811 Quincy St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MABLE MARIE SIMPSON First Middle Last				4. DATE OF DEATH Aug. 30 1956 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11 Oct. 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Standard Coffee Co.		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME Wallace Clark				14. MOTHER'S MAIDEN NAME Sarah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 478-036-510		17. INFORMANT Eilene Johnson 1319 S. W. Street Falls Church, Va. (Daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) (c) Cardio Vascular Renal Disease DUE TO stopping the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 8/31/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/3/56		22c. NAME OF CEMETERY OR CREMATORY OAKLAND Cemetery		22d. LOCATION (City, town, or county) (State) CENTERVILLE IOWA	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS				ADDRESS HEATTSVILLE, Md.		24a. REC'D BY REGISTRAR SEP 7 1956	
				24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT - BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 104

Name of Deceased		John Doe	
Sex		Male	
Age		35	
Date of Death		October 11, 1956	
Place of Death		Washington, D.C.	
Cause of Death		Heart Failure	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Police Officer		[Signature]	

Coroner's Office

Conservative Heart Failure

Cardio Vascular System Disease

BUREAU V. 2

SEP 2 1956

RECEIVED

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

8650

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FORESTVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Forestville</u>			
c. LENGTH OF STAY IN 1b <u>1 month</u>				d. STREET ADDRESS <u>7650 Marlboro Pike, Wash 28 SE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7650 Marlboro Pike, Wash 28 SE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARRIE LEE SMOOT</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Pr Geo County, Ind.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel C. Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Ms. S. Lancaster</u>				Address <u>7650 Marlboro Pike SE Wash 28 SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary with metastases</u> DUE TO <u>175X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>55</u> , to <u>Aug 21</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>56</u> , and that death occurred at <u>10:20</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8/21/56</u>							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				Capitol Heights Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-23-56</u>		<u>Epiphany Episcopal</u>		<u>Forestville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				ADDRESS <u>1661 - 16th St NE Wash D.C.</u>			
24a. REC'D BY REGISTRAR <u>DATE 23 1956</u>				24b. REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Aug 20 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Baltimore</i>	
OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SINGLE <input type="checkbox"/>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		OTHER CAUSE <input type="checkbox"/>	
DATE OF BIRTH <i>Aug 25 1911</i>		PLACE OF BIRTH <i>Germany</i>		CITY OF BIRTH <i>Berlin</i>		COUNTRY OF BIRTH <i>Germany</i>	
DATE OF DEATH <i>Aug 20 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Baltimore</i>	
OCCUPATION <i>Engineer</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		SINGLE <input type="checkbox"/>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		OTHER CAUSE <input type="checkbox"/>	
DATE OF BIRTH <i>Aug 25 1911</i>		PLACE OF BIRTH <i>Germany</i>		CITY OF BIRTH <i>Berlin</i>		COUNTRY OF BIRTH <i>Germany</i>	

BUREAU V. 2

AUG 23 1956

RECEIVED

8623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Prince Georges General Hospital				d. STREET ADDRESS College Park 7204 Bowdoin Avenue			
3. NAME OF DECEASED (Type or print) Siles Flannery Speaks				4. DATE OF DEATH August 19, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1922		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Speaks				14. MOTHER'S MAIDEN NAME Alma Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT mother Address Alma Speaks, wife, Same address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 517x Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstruction of larynx DUE TO (c) Retropharyngeal abscess with edema of larynx.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Transportation 8/24/56				Engle Funeral Home		Hazard Ky.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE 8/27/56		24b. REGISTRAR'S SIGNATURE A.W. Hedrick	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U. S. A.

9561

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08622

8577

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4005 Kennedy Street				d. STREET ADDRESS 4005 Kennedy Street			
3. NAME OF DECEASED (Type or print) First Virginia Middle Lee Last Sprouse				4. DATE OF DEATH Month Aug. Day 7 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 April 1865		9. AGE (In years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Mason Bell				14. MOTHER'S MAIDEN NAME Sarah Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None..		17. INFORMANT Address Alice Gallagher Same add as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cochexia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2m 3 week ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 19 56 , to Aug 7 , 19 56 , that I last saw the deceased alive on July 29 , 19 56 , and that death occurred at AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon W. Kelley M.D.				ADDRESS (Street, city or town, state) 6124-41st Ave Hyattsville Md DATE SIGNED 2/7/56			
PHYSICIAN'S NAME (Type) Gordon W. Kelley				ADDRESS 6124 41st. Ave., Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1956		22c. NAME OF CEMETERY OR CREMATORY Methodist - Protestant		22d. LOCATION (City, town, or county) (State) Alexandria Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE Aug 7 1956	
				24b. REGISTRAR'S SIGNATURE Mrs Jas. Severe			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 1/2 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1207 N. Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Stewart Last 4. DATE OF DEATH Month August Day 27 Year 19 56				5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 18, 1913 9. AGE (In years last birthday) 43 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Harvey Oliver, Same address Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracranial hemorrhage DUE TO (b) Cerebrovascular accident DUE TO (c) Essential hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) John T. Maloney, M.D. DATE SIGNED August 28, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept-1-1956		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. ADDRESS 901 3rd Street, S. W.				24a. REC'D BY REGISTRAR DATE AUG 30 1956		24b. REGISTRAR'S SIGNATURE <i>A. H. Hedrick</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08624

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 303-72nd Street				d. STREET ADDRESS 303-72nd Street			
3. NAME OF DECEASED (Type or print) First Middle Last George Richard Stone				4. DATE OF DEATH Month Day Year Aug 31 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17, 1884	9. AGE (In years last birthday) 71 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. [blank]		17. INFORMANT Mary Stone, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO [blank] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) [blank]							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self by neck with a piece of rope					
20c. TIME OF INJURY Hour 4:30 p.m. Month, Day, Year 8-31-1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Carmody Hills PG MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/56		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Surrey MD	
23. FUNERAL DIRECTOR'S SIGNATURE T. Easchados				ADDRESS Hyattsville, Md		24a. REC'D BY REGISTRAR DATE 8/28/56	
						24b. REGISTRAR'S SIGNATURE Cassie Campbell	

DATE SIGNED

Aug 22, 1956

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

1956 28 AUG

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88625
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8571

CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u></p>				<p>c. LENGTH OF STAY IN 1b <u>1 year</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4904 NIAGARA ROAD</u></p>				<p>d. STREET ADDRESS <u>4904 Niagara Rd.</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Herbert</u> Last <u>Stotler</u></p>				<p>4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1956</u></p>			
<p>5. SEX <u>M.</u></p>		<p>6. COLOR OR RACE <u>W.</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>June 7, 1925</u></p>	
<p>9. AGE (In years, last birthday) <u>31</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u> Hours <u></u> Min. <u></u></p>		<p>IF UNDER 24 HRS. <u></u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk. Railroad</u></p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTHERN PACIFIC</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>West Virginia</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>		<p>13. FATHER'S NAME <u>Sime Stotler</u></p>	
<p>14. MOTHER'S MAIDEN NAME <u>Etta Widmyer</u></p>		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>7-21-43-2-24-46</u></p>		<p>16. SOCIAL SECURITY NO. <u>236-28-5896</u></p>		<p>17. INFORMANT Address <u>Mrs Dennis Stotler 4904 Niagara Rd.</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>198X</u> DUE TO (b) <u>Carcinoma of Left Testicle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u></p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs</u> <u>9 hrs</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.</p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. (City or town) (County) (State)</p>				<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>21. I certify that I attended the deceased from <u>Nov</u>, 1955, to <u>27 July</u>, 1956, that I last saw the deceased alive on <u>27 July</u>, 1956, and that death occurred at <u>2:30 PM</u>, from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>Thos M Hutchins</u> M.D. <u>7315 Landoner Rd Hyattsville Md 1956</u></p>				<p>DATE SIGNED</p>			
<p>PHYSICIAN'S NAME (Type) <u>THOMAS M. HUTCHINS</u></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>22b. DATE THEREOF <u>Aug 3/1956</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL Cem</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VIRGINIA</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., Alexandria, Md.</u> ADDRESS</p>				<p>24a. REC'D BY REGISTRAR DATE <u>Aug 3-1956</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>John D Smith</u></p>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 PM		6. PLACE OF DEATH Prison, Nashville, Tennessee	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. DISEASE OR INJURY Gunshot wound	
10. SIGNATURE OF PHYSICIAN [Signature]		11. SIGNATURE OF CORONER [Signature]		12. SIGNATURE OF DEATH CERTIFICATE OFFICER [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF NEXT OF KIN [Signature]		15. SIGNATURE OF WITNESSES [Signatures]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF WITNESSES [Signatures]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF NEXT OF KIN [Signature]		21. SIGNATURE OF WITNESSES [Signatures]	
22. SIGNATURE OF DECEASED [Signature]		23. SIGNATURE OF NEXT OF KIN [Signature]		24. SIGNATURE OF WITNESSES [Signatures]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF NEXT OF KIN [Signature]		27. SIGNATURE OF WITNESSES [Signatures]	
28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF NEXT OF KIN [Signature]		30. SIGNATURE OF WITNESSES [Signatures]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF NEXT OF KIN [Signature]		33. SIGNATURE OF WITNESSES [Signatures]	
34. SIGNATURE OF DECEASED [Signature]		35. SIGNATURE OF NEXT OF KIN [Signature]		36. SIGNATURE OF WITNESSES [Signatures]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF NEXT OF KIN [Signature]		39. SIGNATURE OF WITNESSES [Signatures]	
40. SIGNATURE OF DECEASED [Signature]		41. SIGNATURE OF NEXT OF KIN [Signature]		42. SIGNATURE OF WITNESSES [Signatures]	
43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF NEXT OF KIN [Signature]		45. SIGNATURE OF WITNESSES [Signatures]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF NEXT OF KIN [Signature]		48. SIGNATURE OF WITNESSES [Signatures]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF NEXT OF KIN [Signature]		51. SIGNATURE OF WITNESSES [Signatures]	
52. SIGNATURE OF DECEASED [Signature]		53. SIGNATURE OF NEXT OF KIN [Signature]		54. SIGNATURE OF WITNESSES [Signatures]	
55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF NEXT OF KIN [Signature]		57. SIGNATURE OF WITNESSES [Signatures]	
58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF NEXT OF KIN [Signature]		60. SIGNATURE OF WITNESSES [Signatures]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF NEXT OF KIN [Signature]		63. SIGNATURE OF WITNESSES [Signatures]	
64. SIGNATURE OF DECEASED [Signature]		65. SIGNATURE OF NEXT OF KIN [Signature]		66. SIGNATURE OF WITNESSES [Signatures]	
67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF NEXT OF KIN [Signature]		69. SIGNATURE OF WITNESSES [Signatures]	
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73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF NEXT OF KIN [Signature]		75. SIGNATURE OF WITNESSES [Signatures]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF NEXT OF KIN [Signature]		78. SIGNATURE OF WITNESSES [Signatures]	
79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF NEXT OF KIN [Signature]		81. SIGNATURE OF WITNESSES [Signatures]	
82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF NEXT OF KIN [Signature]		84. SIGNATURE OF WITNESSES [Signatures]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF NEXT OF KIN [Signature]		87. SIGNATURE OF WITNESSES [Signatures]	
88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF NEXT OF KIN [Signature]		90. SIGNATURE OF WITNESSES [Signatures]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF NEXT OF KIN [Signature]		93. SIGNATURE OF WITNESSES [Signatures]	
94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF NEXT OF KIN [Signature]		96. SIGNATURE OF WITNESSES [Signatures]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF NEXT OF KIN [Signature]		99. SIGNATURE OF WITNESSES [Signatures]	
100. SIGNATURE OF DECEASED [Signature]		101. SIGNATURE OF NEXT OF KIN [Signature]		102. SIGNATURE OF WITNESSES [Signatures]	

BUREAU V. 2

AUG 7 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										88626	
Item 9, Film G201, 8/23/56 bh										Reg. Dist. No. 231	
8625											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b 8 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital					d. STREET ADDRESS 3107 Lake Ave					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lella Surratt					4. DATE OF DEATH Aug 16 19 56						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Aug. 1873		9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Hubbard					14. MOTHER'S MAIDEN NAME Jane E. Saner						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Agnes Humphrie				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Bronchopneumonia DUE TO (b) Cerebral Thrombosis DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1955, to Aug 16, 1956, that I last saw the deceased alive on Aug 15, 1956, and that death occurred at 1:50A M, from the causes and on the date stated above.											
ACTUAL SIGNATURE Norman Daniel Coleman					ADDRESS (Street, city or town, state) 3503 Penny St					DATE SIGNED 8/16/56	
PHYSICIAN'S NAME (Type) Norman Daniel Coleman											
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
Burial			6/18/56		N. Wilkesboro, N.C.			N. Wilkesboro, N.C.			
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
J. Lee & Sons					Washington		AUG 20 1956		Amada Dourney		

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 20 1956

RECEIVED

THE STATE OF CALIFORNIA

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

1

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

68627

8652

CERTIFICATE OF DEATH

Reg. Dist. No. 431

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>PRINCE GEORGES</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - BRANDYWINE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - BRANDYWINE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>D.</u> (Last) <u>SUTHARD (MRS.)</u>				(Month) <u>Aug.</u> (Day) <u>8,</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>April 8, 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DANIEL ALTFATHER</u>				14. MOTHER'S MAIDEN NAME <u>MALINDA WALKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Husband - R.H. Brandywine</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Chronic Myocardial Failure</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Chronic Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Cholecystitis</u>							
19. DATE OF OPERATION <u>Jan 24, 1955</u>				19b. MAJOR FINDINGS OF OPERATION <u>Chronic Cholecystitis</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work Not while at work				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 22, 1955</u> to <u>Aug 8, 1956</u> , that I last saw the deceased alive on <u>July 29, 1956</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Valeh M. Seron</u> M.D.				ADDRESS (Street, city, town, state) <u>Agassac Md</u>		DATE SIGNED <u>8/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 10-56</u>		NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Denton Md</u>	
24. RECD BY REGISTRAR <u>AUG 9 1956</u>		REGISTRAR'S SIGNATURE <u>John F. Danner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>1661 - North Hope Rd</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form No. 10

1. DEATH CERTIFICATE OF DEATH

RECEIVED
AUG 9 1956
BUREAU V. 2

2. DEATH CERTIFICATE OF DEATH

3. DEATH CERTIFICATE OF DEATH

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43. DEATH CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8626

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

086281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swittland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Naval Hosp</u>				d. STREET ADDRESS <u>4100 Brookes Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Janner Meriam Janner</u>				4. DATE OF DEATH <u>Aug 5 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 1 1905</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. AGE (In years last birthday) <u>50</u> yrs.		11. AGE (In years last birthday) <u>50</u> yrs.		12. AGE (In years last birthday) <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter, Building District</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building District</u>			
11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James M. Janner</u>				14. MOTHER'S MAIDEN NAME <u>Blanche B. McDonald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-0781-6</u>			
17. INFORMANT <u>James A. Janner</u>				Address <u>4635 Davis Ave Swittland, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral confluent</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hemothorax</u> DUE TO (c) <u>pneumonia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James L. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES L. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/7/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Clear Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Swittland Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>				ADDRESS <u>mt. Rainier Md</u>			
24a. REC'D BY REGISTRAR <u>AUG 7 1956</u>				24b. REGISTRAR'S SIGNATURE <u>H. H. Smith</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Handwritten signature

BUREAU V. 5

AUG 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8653

CERTIFICATE OF DEATH

Reg. Dist. No.

08629
242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale				c. LENGTH OF STAY IN 1b 45 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE KATHERINE TAYLOR				4. DATE OF DEATH Month Day Year August 18 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 March 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? No	
13. FATHER'S NAME John Paakenen				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elsie M. Owens			
				2204 Clifton Ave. Baltimore, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE (2 Weeks)							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Day Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19 56 , to 18 Aug. 19 56 , that I last saw the deceased alive on 16 Aug. 19 56 , and that death occurred at 12:48 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John R. Buell M.D.</i>				ADDRESS (Street, city or town, state) DATE SIGNED 402 Main St., Laurel, Maryland			
PHYSICIAN'S NAME (Type) John R. Buell M.D.				402 Main St., Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/56		22c. NAME OF CEMETERY OR CREMATORY St. Georges Ch., Cemetery		22d. LOCATION (City, town, or county) (State) Glenn Dale Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR 22 1956	
				24b. REGISTRAR'S SIGNATURE <i>Mrs. John Youngling</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARIZONA STATE DEPARTMENT OF HEALTH-SALTWATER 18

AUG 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8627 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08630

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1028 65th. Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lee Andrew Thomas				4. DATE OF DEATH Month Aug. Day 30 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 22, 1916		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Const., Co., Bldg. Va.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Thomas				14. MOTHER'S MAIDEN NAME Anna Pollard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Jesse W. Thomas (Brother) Same Add. as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status asthmaticus DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchial asthma (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial				22b. DATE THEREOF 8/30/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) (State) S. E. Washington, D.C.				22e. REC'D BY REGISTRAR 2-56			
23. FUNERAL DIRECTOR'S SIGNATURE Rollins Funeral Home Myrtle R. Rollins				24. REGISTRAR'S SIGNATURE Carrie Campbell			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8/30/56

SEP 5 1956

RECEIVED
JUN 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88631

8582

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Floyd</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. Rainier</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 Mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Floyd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3010 Arundel Road</u>				d. STREET ADDRESS <u>Route #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William S. Thompson</u> First Middle Last				4. DATE OF DEATH <u>8-9-56</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14, 1889</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Riverdale, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Hillsville, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>J. J. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Kemp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>2-31-03-5448</u>			
17. INFORMANT <u>Eva Todd</u>				Address <u>3010 Arundel Rd. Mr. Rainier, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peripheral Vascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>15 yrs?</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation left lower limb near hip - June 1956</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 6</u> , 19 <u>56</u> , to <u>Aug. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 7</u> , 19 <u>56</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David B. Clayman</u> M.D.				ADDRESS (Street, city or town, state) <u>6311 Baets Ave. Riverdale, Md.</u>			
DATE SIGNED <u>8.9.56</u>							
PHYSICIAN'S NAME (Type) <u>DAVID S. CLAYMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thompson Family Cem. Dugspur, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley Funeral Home, Inc.</u>				ADDRESS <u>Mr. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>Jas. Seaver</u>	
						24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. B.

AUG 13 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08632

8654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Pr. Geo's Co.</u>		STATE <u>Maryland</u>		COUNTY <u>Pr. Geo's Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glass Manor</u>		<u>1- Year</u>		TOWN <u>Glass Manor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>4904- Deal Drive S.E.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>ROBERT</u>		(Middle) <u>W.</u>		(Last) <u>THORNE</u>		<u>August 13th</u> 19 <u>56</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 8- 1918</u>	<u>37</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Press Operator</u>				<u>Friendly, Maryland.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Sidney Thorne</u>				<u>Katie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>W.W. #2</u>				<u>4904- Deal Drive, SE</u> <u>Estelle F. Thorne (Wife)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Pulmonary Tuberculosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8:30 am</u> <u>1956</u>, to <u>11 pm</u>, <u>1956</u>, that I last saw the deceased alive on <u>8-12</u>, <u>1956</u>, and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Malcolm T. Lunt</u> M.D.				<u>1746 R ST NW D.C.</u> <u>8-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>August 15-56</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>AUG 15 1956</u>		<u>Sidney Thorne</u>		<u>1661- Good Hope Road S</u> <u>Washington, DC</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

8864

Reg. No. 100

TO WHOM THESE PRESENTS COME, I GREET YOU

NAME OF DECEASED: *John P. Jones*

DATE OF DEATH: *Dec 10, 1956*

PLACE OF DEATH: *Home*

AGE: *65*

SEX: *Male*

RACE: *White*

DATE OF BIRTH: *Nov 15, 1891*

CAUSE OF DEATH: *Heart Disease*

DATE OF DEATH: *Dec 10, 1956*

PLACE OF DEATH: *Home*

DECEASED'S RESIDENCE: *1234 Main St, Baltimore, Md*

DECEASED'S OCCUPATION: *Teacher*

DECEASED'S MARITAL STATUS: *Married*

DECEASED'S SEX: *Male*

DECEASED'S RACE: *White*

DECEASED'S AGE: *65*

DECEASED'S DATE OF BIRTH: *Nov 15, 1891*

DECEASED'S PLACE OF BIRTH: *Baltimore, Md*

Heart Disease

John P. Jones

DECEASED'S RESIDENCE: *1234 Main St, Baltimore, Md*

DECEASED'S OCCUPATION: *Teacher*

DECEASED'S MARITAL STATUS: *Married*

DECEASED'S SEX: *Male*

DECEASED'S RACE: *White*

DECEASED'S AGE: *65*

DECEASED'S DATE OF BIRTH: *Nov 15, 1891*

DECEASED'S PLACE OF BIRTH: *Baltimore, Md*

BUREAU V. 8

AUG 15 1956

RECEIVED

REGISTERED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

AND IS SUBJECT TO THE REVIEW OF THE MARYLAND DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08633

Reg. Dist. No. 241

8578

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges																		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville			c. LENGTH OF STAY IN 1b 6 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville																		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9301 19th Avenue				d. STREET ADDRESS 9301 19th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) Ruth Lynner Van Herpe				4. DATE OF DEATH August 26 1956																		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-1902		9. AGE (In years last birthday) 53 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.									
IF UNDER 1 YEAR	IF UNDER 24 HRS.																					
Months	Days																					
Hours	Min.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) N. Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.																
13. FATHER'S NAME Lars Lynner				14. MOTHER'S MAIDEN NAME Callie -----																		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Leo J. Van Herpe, Same address																		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> DUE TO </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> </tr> <tr> <td colspan="2"> (b) Hypertensive cardiovascular disease </td> <td></td> </tr> <tr> <td colspan="2"> DUE TO </td> <td></td> </tr> <tr> <td colspan="2"> (c) </td> <td></td> </tr> </table>							PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X		INTERVAL BETWEEN ONSET AND DEATH	DUE TO		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Hypertensive cardiovascular disease			DUE TO			(c)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X		INTERVAL BETWEEN ONSET AND DEATH																				
DUE TO																						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																						
(b) Hypertensive cardiovascular disease																						
DUE TO																						
(c)																						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.																						
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>																		
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED August 26, 1956																		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/28/56		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.																
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Silver Spring, Md.</i>				24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE <i>James S. Sere</i>																

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1956 08 28

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1956 08 28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08634

8628

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Heland Memorial</u>		d. STREET ADDRESS <u>95X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA JANE Vinnds</u>		4. DATE OF DEATH Month Day Year <u>August 6 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-81</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. A.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Henry Willow</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Wiley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Patients chart.</u>	
17. INFORMANT Address <u>Patients chart.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of ovary with metastases</u> 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 6, 1944</u> , to <u>Aug 6, 1956</u> , that I last saw the deceased alive on <u>Aug 6, 1956</u> , and that death occurred at <u>11:38</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>8-6-56</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. King St.</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch Sons Hgatterly</u> ADDRESS <u>Martinsburg W. Va.</u>		24. REC'D BY REGISTRAR <u>Aug 6 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

BUREAU V. 5

6 AUG 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8655

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Englewood</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Englewood</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hone</u>				d. STREET ADDRESS <u>1624 62nd Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Michelle Lynn Wallace</u>				4. DATE OF DEATH <u>8/10/56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/56</u>		9. AGE (In years last birthday) yrs. <u>0</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hone</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hone</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris F. Wallace Jr</u>				14. MOTHER'S MAIDEN NAME <u>Myrna Loy Hemingway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Morris F. Wallace Jr (Father)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>child was mongoloid</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hone</u>					
20c. TIME OF INJURY a. h. _____ m. _____ b. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6/20</u> , 19 <u>56</u> to <u>8/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>56</u> , and that death occurred at <u>2 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald H. Sheppard</u> M.D.				ADDRESS (Street, city or town, state) <u>1924 19th St. NW. Washington D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Donald H. Sheppard</u>				DATE SIGNED <u>8/10/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY CEMETERY</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. ...</u>				24a. REC'D BY REGISTRAR <u>20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>D. H. ...</u>	

CERTIFICATE OF DEATH

Handwritten entries on the certificate form, including names like "John F. Williams" and dates like "8/10/56".

BUREAU V. S.

AUG 20 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8656

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS Apt. # 101 2018 37th Street, S.E.			
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Viola Williams				4. DATE OF DEATH Month Day Year August 4, 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Johnstown, Pa.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Mintmier				14. MOTHER'S MAIDEN NAME --- Rader			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Records at Suitland Nursing Home				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Acute Congestive Failure DUE TO Multiple Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of Colon (c)							INTERVAL BETWEEN ONSET AND DEATH 3 Days 9 Months 2 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 19 Sept., 1954, to August 4, 1956, that I last saw the deceased alive on August 3, 1956, and that death occurred at 10:35 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sidney W. Lowry M.D. 7200-MARLBORO PIKE SE. PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY MD WASH. 28 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 8/4/56		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) Johnstown, Pennsylvania				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS 2901 14th St., N.W. Washington 9, D.C.		24. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Carrie Campbell							

CERTIFICATE OF DEATH

2878

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. TIME OF DEATH [Illegible]</p>		<p>8. PLACE OF DEATH [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>12. SIGNATURE OF REGISTRAR [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS [Illegible]</p>		<p>14. SIGNATURE OF DECEASED [Illegible]</p>	

BUREAU V. 1

AUG 5 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8629

CERTIFICATE OF DEATH

08637

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
		d. STREET ADDRESS 02X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hattie Middle V Last Wilson		4. DATE OF DEATH Month Aug. Day 15 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Sept
9. AGE (In years last birthday) 72 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Taylor		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Norman T. Wilson		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs year year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 14, 1956 , to Aug 15, 1956 , that I last saw the deceased alive on Aug 14, 1956 , and that death occurred at 7:15 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		ADDRESS (Street, city or town, state) RFD Bowic Md	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 8/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/56	
22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR Aug 20 1956		24b. REGISTRAR'S SIGNATURE Amador Arroyo	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John J. Wilson		Male		45		1911		Maryland		Baltimore		Heart Disease		Home		10:30 AM		J. J. Wilson		J. J. Wilson	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Place	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		1956		10:30 AM		Catholic Cemetery	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Place of Death	
1956		10:30 AM		Home		Heart Disease		Home		10:30 AM		Home		Heart Disease		Home		10:30 AM		Home	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson		J. J. Wilson	

BUREAU V. 2

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08638
8657 CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 8 mo's, 15 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1817 Kendall St., N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Levi		Middle C.		Last Wright	
4. DATE OF DEATH		Month August		Day 14		Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/03		9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs, self emp'd.		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi G. Wright				14. MOTHER'S MAIDEN NAME Annie Ball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) right lung, Bronchogenic Carcinoma with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/30 , 19 55 , to 8/14 , 19 56 , that I last saw the deceased alive on 8/14/56 , 19 56 , and that death occurred at 3:50p.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Daniel Leo Finucane M.D.				Glenn Dale Hospital, Glenn Dale, 8/14/56 Maryland			
PHYSICIAN'S NAME (Type) Daniel Leo Finucane							
22a. BURIAL CREMATION, REMOVAL (Specify) F		22b. DATE THEREOF 8/15/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John L. Stewart				ADDRESS 304 H St NE		24a. REC'D BY REGISTRAR DATE 8/14/56	
						24b. REGISTRAR'S SIGNATURE Wm Weiss	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8658

CERTIFICATE OF DEATH

Reg. Dist. No.

08639 242

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			c. LENGTH OF STAY IN 1b 25 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland Wash. 23, D.C.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5618 Belt Avenue				d. STREET ADDRESS 5618 Belt Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST RAPHAEL LAWRENCE ZWINGLAS				4. DATE OF DEATH August 18th, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2nd, 1901	
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury Dept.		11. BIRTHPLACE (State or foreign country) Old Bridge, N.J.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME VINCENT Z WINGLAS				14. MOTHER'S MAIDEN NAME ANNA ADAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. Noen		17. INFORMANT Ruby E. Zwinglas, 5618 Belt Ave. Wash. 23	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic myocarditis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hr unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1956, to Aug 18, 1956, that I last saw the deceased alive on Aug 17, 1956, and that death occurred at 3:15 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul P Van Natta				M.D. 5440 Silver Hill Rd			
PHYSICIAN'S NAME (Type) PAUL P VAN NATTA				Washington 28 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug/22/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. S.E. Wash. DC				24a. REC'D BY REGISTRAR DATE Aug 21, 56		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

U. S. DEPT. OF JUSTICE

1936

RECEIVED